Senate / 100th Congress / 2d Session / Document No. 100-28

What Should the Federal Government Do to Enhance the Quality of Life for United States Citizens Over Age 65?

National Debate Topic for High Schools
1988-1989

Pursuant to Public Law 88-246

Compiled by the Congressional Research Service
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U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON: 1988

PUBLIC LAW 88-246, 88TH CONGRESS, S. 2311,
DECEMBER 30, 1963

AN ACT To provide for the preparation and printing of compilation of materials relating to annual national high school and college debate topics.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Librarian of Congress is authorized and directed to prepare compilations of pertinent excerpts, bibliographical references, and other appropriate materials relating to (1) the subject selected annually by the National University Extension Association and the national high school debate topics and (2) the subject selected annually by the American Speech Association as the national college debate topic. In preparing such compilations the Librarian shall include materials which in his judgment are representative of, and give equal emphasis to, the opposing points of view on the respective topics.

Sec. 2. The compilations on the high school debate topics shall be printed as Senate documents and the compilations on the college debate topics shall be printed as House documents, the cost of which shall be charged to the congressional allotment for printing and binding. Additional copies of such documents may be printed in such quantities and distributed in such manner as the Joint Committee on Printing directs.

Approved December 30, 1963.

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Congressional Research Service
The Library of Congress

Washington, D.C. 20540

FOREWORD

The 1988-1989 high school debate topic is, "What should the Federal Government do to enhance the quality of life for United States citizens over age 65?" The three official debate propositions within this topic are:

RESOLVED:	That the Federal Government should implement a comprehensive program to guarantee retirement security for United States citizens over age 65.
RESOLVED:	That the Federal Government should guarantee adequate custodial care for United States citizens over age 65.
RESOLVED:	That the Federal Government should guarantee long-term health care for United States citizens over age 65.

In compliance with Public Law 88-246, the Congressional Research Service of the Library of Congress prepared this compilation of materials and bibliographic references to assist high school debaters in researching the topic. Excerpts from documents were selected to provide background information, an overview of the principal issues, and a balance of opposing views. We have included some materials that are not readily available in public or research libraries. In selecting items for this reader and bibliography, the Congressional Research Service (CRS) has attempted to sample the wide spectrum of opinions reflected in current literature on these questions. No preference for any policy is indicated by the selection or positioning of articles herein, nor is CRS disapproval of any policy or article to be inferred from its omission.

A research guide is included at the end of this volume; it is intended to help debaters identify further references and organizational resources on their own. Also included is a list of relevant publications that are available for purchase from the Superintendent of Documents, Government Printing Office. Some of the U.S. Government documents listed in the manual may be found in U.S. Government depository libraries, which can be identified by local public libraries. The Library of Congress cannot distribute copies of these or other materials to debaters.

The documents presented in this compilation were selected by Edith Deer Sutterlin, Senior Bibliographer, Library Services Division, with assistance from Carol O'Shaughnessy, Specialist in Social Legislation and Richard Price, Specialist in Social Legislation, Education and Public Welfare Division, and Louis Alan Talley, Research Analyst in Taxation, Economics Division. In addition, many other CRS analysts provided recommendations on the selections. Ms. Sutterlin prepared the bibliography and guide to information sources. Technical production was made possible by Martha Lederer and Sherry B. Shapiro, Library Services Division.

Good luck to each debater in researching, preparing, and presenting arguments on this year's topic.

Joseph E. Ross, Director
Congressional Research Service

GENERAL MATERIALS

Reproduced from U.S. Congress. Senate. Joint Economic Committee. Subcommittee on Economic Resources, Competitiveness, and Security Economics. Demographic changes in the United States: the economic and social consequences into the 21st century. Hearings, 99th Congress, 2nd session. Washington, G.P.O., 1987. p. 26-49 (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-1088)

PREPARED STATEMENT OF JOHN G. KEANE

CENSUS BUREAU INSIGHTS AND IMPLICATIONS REGARDING AN AGING SOCIETY

INTRODUCTION

In less than 25 years, a large, elderly population will be a reality in America. Previous fertility patterns as well as improvements in life expectancy will result in a large number and proportion of persons aged 65 years or older than the United States has ever experienced before. These demographic conditions represent only one factor among many that will influence future economic prospects; the growth of the elderly population, however, is a virtual certainty and knowledge allows for planning.

DEMOGRAPHIC BACKGROUND

The primary basis for the future dramatic growth of the elderly population (Table 1, Chart 1) lies in the period from 1946 to 1964, when 75 million persons were born. The baby-boom generation, those born during that period, totaled 70 percent more people than were born during the preceding two decades and now represent about one-third of the U.S. population. As they age, the impact of the size of the baby-boom population continues to be felt on a wide variety of institutions as well as at the personal level.

Fluctuations in the sizes of different age groups can have dramatic effects on our economy, as recent history demonstrates. From the 1950s through the mid-1970s (Charts 2-4), American society was adjusting to the size and needs first of its babies and then of its teenagers. Elementary

John G. Keane, Director, Bureau of the Census schools sprouted up everywhere only to be closed or converted to other uses during the 1970s. From 1950 to 1980, the teenage and young adult population grew by an average of three percent a year (Table 2, Chart 5). Rates of college enrollment and unemployment among young people increased. At the same time, the aged population grew at an even faster rate than the youth, due primarily to lower mortality, but their numbers were small relative to the size of the baby-boom generation. By the year 2010, the baby-boom generation will begin to reach age 65 and society and the economy will have to adjust to a large elderly population.

Dramatic improvements in life expectancy have also contributed to the growth of the elderly population. Between 1900 and 1984, life expectancy at birth rose by 60 percent, from 47 years in 1900 to 75 years in 1984 (Chart 6). Women who now live to age 65 have, on average, an additional 19 years of life, and men, another 15 years (Chart 7). Death before the mid-60's is now relatively rare. More and more, children will know not only their grandparents, but also their great-grandparents (mostly their great-grandmothers) as four living generations become commonplace.

AGE STRUCTURE IN THE 21ST CENTURY

What will the age structure look like beyond 1985 (Chart 8) and into the 21st century? By making certain assumptions about levels of fertility, mortality, and immigration, we can project the future size and age distribution of the population. The numbers that I will discuss represent our middle series of projections and thus do not anticipate any significant changes in any of the components of population change. Table 1 additionally shows projections under different assumptions about fertility, mortality, and migration.

For the next 25 years (Chart 9), the elderly population will continue to increase steadily but not dramatically. In 2005 (Chart 10), the oldest members of the baby boom will be nearing age 60 and the youngest members will have just passed age 40. As the postwar baby-boom cohorts begin to reach age 65 starting in the year 2011, the number of elderly persons and the ratio of elderly persons to persons under age 20 will begin to rise dramatically. From 2010 to 2030, growth will virtually halt for any age group other than the elderly (Table 2, Chart 11), and the number of persons 65 and over will jump from 39 million to 65 million and from 13 to 21 percent of the total population (Table 1).

By 2025 (Chart 12), the baby-boom cohort will be 60 to 80 years of age. The proportion of the population under age 20 will be 27 percent compared with the 40 percent seen in 1965 when the baby-boom group was young. In 2025, we will have nearly as many people over 60 as we have under 20 years of age.

The size of the elderly population in 2030 will be at least 2 1/2 times the size of the elderly population in 1980. The proportion elderly in the total population will be significantly higher, from every 9th American to every 5th American. The proportion of elderly in the U.S. population will, by 2020, reach 17 percent, the same as that of our "oldest" state today, Florida.

Beginning in about 2025, the final phase of the gerontological explosion caused by the baby-boom generation will begin. There will be significant growth only among the very oldest after 2025 (Chart 13), as the baby-boom generation reaches 80 years and older. The growth of the younger segment of the elderly population will have begun to decelerate as persons born in the baby-bust period following 1965 reach age 65. The aging of the aged, the great-grandma boom, will be upon us as the cohort born from 1946 to 1964 swells the size of the 80 and over population. Today, the 80 and over group numbers about 5.9 million; in 2030, they are expected to number about 17 million and by 2050 (Chart 14), they could reach 26 million. If greater reductions in mortality rates than now anticipated were to occur, even these figures would understate the size of the future older aged population (Table 1). Today, every 40th American is 80 years or older; in 2050, at least every 12th person would be 80 years or older.

CHARACTERISTICS OF THE OLDER POPULATION

To understand the effect of the older population on our society, we must look not only at the size of that population but also at their characteristics. The population 65 years and over, commonly referred to as "the elderly," are demographically, socially, economically, and physically a heterogeneous population. It is very different to be part of a healthy, 65-year-old married couple with Social Security and a work-related pension than it is to be an 85-year-old widow with severe arthritis and a chronic heart condition and the minimum Social Security benefit.

Beyond the personal level, there are considerable differences among age groups in terms of their size, level of educational attainment, lifetime economic experience, and so forth, all of which have implications for the health and social-economic well-being of the aged. The extension of life will result in large numbers of economically and physically vigorous old people along with large numbers of chronically ill, dependent persons.

Today's elderly are different from the rest of the population in many ways and, although we cannot predict that existing differences will persist into the future, we should be aware of those differences in designing public policy for the elderly. The work and savings patterns of the current generation of young and middle-aged people give us definite hints about their likely economic status as they age. Furthermore, certain economic characteristics of the elderly population such as income are very closely tied to public policy decisions.

As is now true, women will continue to sharply outnumber men. In 2030, projections indicate that there will be more than twice as many women 80 and over as there are men that age. Aged women are often widowed, live alone, and experience a disproportionate degree of poverty. Elderly men, on the other hand, are much more likely to be married than widowed; most, therefore, live in a family setting. These differences are due to death rates of elderly married men that are 2 1/2 times higher than those of elderly married women, the far higher remarriage rates of elderly men (seven times higher), and the tendency of the elderly men who marry to marry women under age 65 (who are more likely to be in the labor force and have more economic resources than older women) as well as women over 65.

Patterns of marital status and living arrangements shift considerably with advancing age. While the changes follow the same general course for elderly women and men, they are much more dramatic for women. In 1984, four out of five men aged 65 to 74, and two out of three men age 75 and over were married and living with their wives. But only half of the women aged 65 to 74 were married and living with their husbands and less than one in four women 75 and over lived with their husband.

Associated with these marital status changes are pronounced changes in the living arrangements of elderly women. The most notable is the sharp increase in the proportion of women living alone, and the sharp decline in the proportion of women living with other family members. There has been relatively little change in living arrangements of elderly men. The increased tendency of older women to live alone is likely to continue: it is expected that by 1995, over 60 percent of the women 75 years and over will be living alone as compared with 50 percent in 1984. The trend towards independent living has come about partly as a result of improvements in economic status, partly from a desire to be independent, and partly from simple lack of another alternative.

Older persons mostly "stay put." Less than 5 percent of the elderly changed their place of residence in 1983-1984, and usually the move was within the same county. Many live out their lives in small-town America or in certain sections of our large cities, especially the inner, deteriorated sections. Enclaves of older persons have long been evident in large cities, but concentrations of elderly people are now appearing in metropolitan suburbs as well, albeit in a more dispersed form, resulting from the large postwar migration to these areas.

What long-distance movement the elderly have participated in has tended to be out of the Northeastern states into the South and West, particularly out of the Middle Atlantic states and into the South Atlantic and Mountain states.

The aging of the nation's population is reflected in the record of most states. In 1983, Florida led all other states by far in its proportion of elderly, with 17.6 percent age 65 and over. Many Midwestern farm-belt states - Iowa, South Dakota, Missouri, Nebraska, and Kansas - as well as Rhode Island, Pennsylvania, Maine, and Massachusetts also have relatively high proportions of elderly (13 percent or more) as compared with the national average of 11.9 percent. Several Western states - Utah, Wyoming, Colorado, Nevada, New Mexico - and the South - Texas, Louisiana, Georgia - as well as Alaska and Hawaii, have less than 10 percent elderly among their populations. Low proportions of the elderly tend to occur in states with high in-migration of young adults and with high fertility.

No other aspect of life for the elderly is as directly tied to policy decisions as their economic well-being. Labor force participation, income, and the accumulation of assets over the younger years are all closely related to the need for Social Security and other pension plans, Medicare regulations, and even certain tax laws. Many of the changes in the economic status of the elderly in recent years are direct results of federal policies developed in earlier years directed towards both the young and the old.

During the last few decades there have been sharp declines in the proportion of older men in the labor force while the proportion of older women in the labor force has risen moderately. The decline in labor force participation of older men reflects the combined effects of an increase in voluntary retirement associated with the more widespread eligibility of workers under Social Security and other pension plans, the increase in disability retirements, and other labor market conditions which tend to discourage older workers. Another important factor is the growing financial ability of older workers to retire, which is associated with the growth in retirement programs.

It is difficult to predict how increases in the age of eligibility for full Social Security benefits will affect the trend towards early retirement because benefit levels are only one part of the decision to retire. It may reduce early retirement somewhat but there is a significant minority who retire early because they have little choice. Today, from one-third to one-half of those who retire early say they did so because of health or lack of employment prospects; thus, we may expect to see increased use of the unemployment and disability insurance systems. Changes in our occupational structure will also affect the ability of the elderly with physical limitations to work.

In terms of the future, the potential pool of workers will decline, as a result of the decline in the number of births after the mid-1960's and through the 1970's, Some predict that the reduced size of the younger population will lessen the pressure on the older population to retire early. But increased participation of women of all ages in the labor force could mean that older persons will still be competing for work, particularly part-time work.

A relatively high proportion of the baby-boom generation are white-collar workers who traditionally have been more likely to want to continue working as they get older. Whether jobs will be available for older workers in the future is not clear.

Steady employment at younger ages is important partly because the single most important source of income for the elderly is Social Security benefits. Data from the Current Population Survey show that about one-fifth of the elderly population received virtually all (90 percent or more) of their income from Social Security. For over half, the benefits constituted over half of their income. Since many such persons had low earnings when they were working, they are probably receiving benefits near or below the poverty line. One's work experience as a young person can affect one's economic status as an older person. High unemployment of young Black males, for example, is not just a problem of youth. Long periods of unemployment (or work in jobs without private pension systems) reduce the retirement benefits available when one is elderly.

The great majority of elderly persons are not poor even though elderly persons are more likely to be poor than younger persons. Poverty among the elderly population was considerable up until a few decades ago, but the proportion with incomes below the poverty level has been falling sharply, reaching 12.4 percent in 1984 for the elderly overall. But, the elderly are not a homogeneous group subject to sweeping generalizations. The poverty rate is much lower than 12.4 percent for some segments of the elderly population but much higher for others. Higher poverty levels are more likely to occur among those who live alone (Figs. 15-18), and families maintained by women (Fig. 15 and 16) and by Blacks (Fig. 17). For example, in 1979, the poverty rate for all persons 65 years and over was 15 percent, but the poverty rate for males 65 to 74 years old who lived in families was 7 percent; if they lived alone, it was 22 percent. For women that age, the rates were slightly higher, 8 percent and 27 percent respectively. The poverty rate also increases with advancing age: for example, the poverty rate for Black women 65-74 years old who lived alone was 58 percent, but for Black women 85 years and over who lived alone, it was 73 percent (Table 3).

Although the elderly as a group have lower income levels than younger persons, a number of studies show improved economic status among certain segments of the population. There is evidence from the 1980 census which suggests that assets of many older persons remain intact or increase even while current income decreases. From the Survey of Income and Program Participation (SIPP), we found that the median net worth of those 65 years and over is greater than for any other age group when income levels are held constant. Even when the value of home equity is removed, asset levels of the elderly still exceed those of other ages (Table 4). Among the elderly with assets, major assets include deposits at finanicial institutions, other interest-earning assets, stocks and mutual fund shares, rental property, and homes (Table 5). A sizeable "young-old" population with incomes greater than the median for all households may well become more and more likely in future years, even as we continue to have a significant minority of poor elderly, particularly among the oldest old. Health costs, for example, can make an enormous difference in the economic status of the oldest old as they use assets to cover serious, long-term illnesses. Longer life expectancy has not necessarily translated into better health. It is possible that chronic, serious, and expensive health problems may increase as the population ages.

Tomorrow's elderly will be very different from today's elderly in some important characteristics that bear on their ability to function effectively in old age. For example, the relatively high educational attainment of the baby-boom generation bodes well for their lifetime economic status, and as a result, the opportunity to provide for their old age. Research has also shown that those with higher levels of education tend to have better overall health and longer life expectancy. In 1985, 86 percent of those aged 25 to 44 years were high school graduates compared with only 40 percent of the elderly. One fourth of the baby-boom generation had completed 4 or more years of college, and 10 percent had 5 or more years of college; for persons 65 years and over, the percentages were 9 and 3 respectively. Another indication that the future elderly population will probably have a very different retirement experience than today's elderly is based on changes in occupational patterns. Today's elderly women, especially Black women, are much more likely to have been employed in occupations that were not formerly covered by Social Security. Younger women, on the other hand, are much more likely to be employed in occupations covered by Social Security and other pension plans, and thus, are more likely to be in better financial shape in old age than their grandmothers are today.

SOCIAL AND ECONOMIC IMPLICATIONS OF AN AGING SOCIETY

Because of the demographic conditions that exist today, as a nation, we will be much "older" in the next century and consequently, the nature of American society will be vastly different from today. High proportions of elderly persons relative to the number of productive workers, continued low fertility and very low mortality, all could have profound social and economic consequences. In looking toward this future, we should recognize that careful planning goes beyond devising ways to accommodate and care for this burgeoning group. It should also consider the societal impact of a much older age structure and the consequences for individuals of all ages. Further, it should consider the tremendous variation in health and economic status within a heterogenous elderly population.

Two major fears about old age concern health and economic status. When one of every twelve Americans is 80 years or older, health care and especially catastrophic and long-term care services will require an increasingly greater share of the GNP than is now spent. Currently, the Federal government spends about $51 billion on the population 80 years and over. With the greatly increased projected number of very old persons, under current policy we can expect even higher costs for this group. Catastrophic illness and illnesses of long duration are always a significant threat, even to the elderly with good economic resources, because they have little opportunity to replace their assets once they are spent. Personal resources and family help which were adequate in the past may not meet the needs of tomorrow's elderly with their greater life expectancy.

Aside from the very important and obvious issue of providing health care, there will be other policy decisions with potentially wide-ranging impact on the future economic status of the elderly. These include laws affecting workers, taxpayers, and employers, and dealing with such issues as leave for parental care, tax breaks for parental care, pension portability, tax incentives for retirement saving, and so on. Along with spending for health care, the GNP may also be affected by pension plan payouts for members of the baby-boom generation as they retire.

In fact, the aging of the baby-boom generation presents a novel situation. We can only try to anticipate some of the problems and solutions that will ultimately evolve. To adequately monitor the dramatic changes requires a sophisticated statistical system and study of the experience of other nations. At the Census Bureau, we have been working to improve our statistics on the older population. Along with the National Institute on Aging, the Census Bureau sponsored a meeting last May of the directors of federal agencies concerned with aging-related statistics. We agreed to establish an Interagency Forum on Aging-Related Statistics that will extend our individual capabilities through cooperative efforts. A statement of the highlights of that meeting with a list of participants is submitted for the record.

The essential structure of the Social Security system was based on the demographic situation of the 1930's, when a large workforce could be depended upon to support a relatively small elderly population. Soon, the situation will be quite different. Policy makers are already trying to devise alternative ways to keep the system vital in light of these demographic changes. From the perspective of our national economy, we must consider not just the obvious impact of a large older population but the consequences of a smaller workforce. The health of the American economy has been in part a function of a large and highly skilled workforce. As the labor force ages, both private and public institutions can be expected to try to devise ways to make better use of the work force, improving productivity and finding ways to keep older workers in the labor force longer.

America, and much of the rest of the world, are aging societies. If we as a society anticipate and plan now for all age groups, then individuals and families will be better able to adjust their own expectations and plan for their futures. The magnitude of change can be foreseen to some extent and presents a challenge to adapt public policy far enough in advance to be successful.

TABLE 1

THE GROWTH OF THE OLDER POPULATION
ACTUAL AND PROJECTED 1900-2050
(Numbers in thousands)

	Total	55 to 64 years		65 to 74 years		75 to 84 years		85 years and over		65 years and over		75 years and over	
Year	Number	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1900	76,303	4,009	5.3	2,189	2.9	772	1.0	123	0.2	3,084	4.0	895	1.2
1910	91,972	5,054	5.5	2,793	3.0	989	1.1	167	0.2	3,954	4.3	1,156	1.3
1920	105,711	6,532	6.2	3,464	3.3	1,259	1.2	210	0.2	4,933	4.7	1,469	1.4
1930	122,775	8,397	6.8	4,721	3.8	1,641	1.3	272	0.2	6,634	5.4	1,913	1.6
1940	131,669	10,572	8.0	6,375	4.8	2,278	1.7	365	0.3	9,019	6.8	2,643	2.0
1950	150,697	13,295	8.8	8,415	5.6	3,278	2.2	577	0.4	12,295	8.1	3,855	2.6
1960	179,323	15,572	8.7	10,997	6.1	4,633	2.6	929	0.5	16,560	9.2	5,562	3.1
1970	203,302	18,608	9.2	12,447	6.1	6,124	3.0	1,409	0.7	19,980	9.9	7,533	3.7
1980	226,505	21,700	9.6	15,578	6.9	7,727	3.4	2,240	1.0	25,544	11.3	9,967	4.4
1984	236,416	22,210	9.4	16,596	7.0	8,793	3.7	2,596	1.1	28,040	11.9	11,389	4.8
Middle Series: 1/													
1990	249,657	21,053	8.4	18,035	7.2	10,349	4.1	3,313	1.3	31,697	12.7	13,662	5.5
2000	267,955	23,767	8.9	17,677	6.6	12,318	4.6	4,926	1.8	34,921	13.0	17,244	6.4
2010	283,238	34,848	12.3	20,318	7.2	12,326	4.4	6,551	2.3	39,195	13.8	18,877	6.7
2020	296,597	40,298	13.6	29,855	10.1	14,486	4.9	7,081	2.4	51,422	17.3	21,567	7.3
2030	304,807	34,025	11.2	34,535	11.3	21,434	7.0	8,612	2.8	64,581	21.2	30,046	9.9
2040	308,559	34,717	11.3	29,272	9.5	24,882	8.1	12,834	4.2	66,988	21.7	37,716	12.2
2050	309,488	37,327	12.1	30,114	9.7	21,263	6.9	16,034	5.2	67,411	21.8	37,297	12.1
High Series 2/													
1990	254,122	21,109	8.3	18,182	7.2	10,428	4.1	3,380	1.3	31,990	12.6	13,808	5.4
2000	281,542	24,212	8.6	18,113	6.4	12,747	4.5	5,386	1.9	36,246	12.9	18,133	6.4
2010	310,006	35,970	11.6	21,171	6.8	13,140	4.2	7,756	2.5	42,067	13.6	20,896	6.7
2020	340,762	42,537	12.5	31,554	9.3	15,762	4.6	9,016	2.6	56,332	16.5	24,778	7.3
2030	369,775	36,804	10.0	37,400	10.1	23,770	6.4	11,410	3.1	72,580	19.6	35,180	9.5
2040	398,521	38,373	9.6	32,564	8.2	28,426	7.1	17,568	4.4	78,558	19.7	45,994	11.5
2050	427,900	44,048	10.3	34,246	8.0	25,063	5.9	23,416	5.5	82,725	19.3	48,479	11.3
Low Series 3/													
1990	245,753	20,910	8.5	17,925	7.3	10,226	4.2	3,201	1.3	31,352	12.8	13,427	5.5
2000	256,098	23,326	9.1	17,290	6.8	11,887	4.6	4,444	1.7	33,621	13.1	16,331	6.4
2010	261,482	33,836	12.9	19,525	7.5	11,537	4.4	5,486	2.1	36,548	14.0	17,023	6.5
2020	262,695	38,648	14.7	28,332	10.8	13,271	5.1	5,532	2.1	47,135	17.9	18,803	7.2
2030	257,443	32,023	12.4	32,286	12.5	19,310	7.5	6,490	2.5	58,086	22.6	25,800	10.0
2040	246,459	32,090	13.0	26,778	10.9	21,947	8.9	9,391	3.8	58,116	23.6	31,338	12.7
2050	232,222	31,335	13.5	27,008	11.6	18,241	7.9	11,088	4.8	56,337	24.3	29,329	12.6

Bureau of the Census, Decennial Census of Population, 1900-1980 and Projections of the Population of the United States 1982 to 2080, Series P-25, No. 952, 1984.

1/ Assumes a total fertility rate of 1900, life expectancy at birth of 79.6 years, and net immigration of 450,000 per year.
2/ Assumes a total fertility rate of 2300, life expectancy at birth of 83.3 years, and net immigration of 750,000 per year.
3/ Assumes a total fertility rate of 1600, life expectancy at birth of 76.7 years, and net immigration of 250,000 per year.

TABLE 2 - POPULATION CHANGE: 1950-2050
(Average Annual Percent Change)

Life Cycle Stage	Age	1950-1980	1980-2010	2010-2030	2030-2050
Preschool	Under 5 years	0	0.3	0.1	0
School Age	5-13	1.3	0.1	0.2	-0.1
	14-17	3.0	-0.2	0.1	-0.2
Young Adult	18-24	3.0	-0.3	-0.3	-0.1
Child Rearing	25-34	1.9	-0.1	0	0.2
	35-44	0.7	1.4	0.5	-0.2
Empty Nest	45-64	1.5	2.5	0.4	0.2
Young Old	65-74	2.8	1.0	3.5	-0.6
Aged	75-84	4.5	1.9	3.7	0
Oldest Old	85+	9.5	6.3	1.6	4.3

SOURCE: Bureau of the Census, 1950 and 1980 Decennial Censuses; and "Projections of the Population of the United Stated, by Age, Sex, and Race: 1983 to 2080," Series P-25, No. 952, Middle Series, Government Printing Office, 1984.

Table 3

Noninstitutionalized Persons 60 Years and Over, By Race, Sex, and Level of Poverty in 1979: 1980--Continued

	AGE						AGE SUMMARIES					
PERCENT	60-64	65-69	70-74	75-79	80-84	85+	60+	65+	75+	80+	65-74	75-84
TOTAL MALE												
In families	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	5.9	6.6	7.8	9.6	10.1	10.8	7.3	8.0	9.9	10.3	7.1	9.8
Below 125% poverty	8.8	10.7	13.2	16.2	17.2	18.4	11.8	13.3	16.8	17.6	11.7	16.5
Living alone	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	21.5	20.9	23.3	25.5	24.5	26.7	23.1	23.6	25.4	25.4	22.0	25.1
Below 125% poverty	29.2	33.3	37.1	40.1	41.0	44.3	36.0	37.9	41.3	42.4	35.1	40.5
TOTAL FEMALE												
In families	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	7.3	7.5	8.5	9.3	8.6	8.1	7.9	8.2	8.8	8.4	7.9	9.0
Below 125% poverty	11.1	12.3	14.1	15.4	14.6	14.0	12.8	13.7	14.9	14.3	13.1	15.1
Living alone	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	27.7	26.2	27.6	29.8	33.1	40.0	29.4	29.7	32.8	35.6	26.9	31.1
Below 125% poverty	35.9	39.6	43.8	48.8	53.1	58.8	44.9	46.7	52.1	55.2	41.8	50.5
BLACK MALE												
In families	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	16.4	19.8	23.0	25.7	26.1	28.1	20.6	22.7	26.3	26.9	21.1	25.8
Below 125% poverty	23.2	28.9	34.5	38.3	38.7	41.0	30.1	33.6	38.9	39.6	31.2	38.4
Living alone	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	38.2	39.7	45.3	50.0	50.0	53.5	43.4	45.3	50.7	51.4	42.1	50.0
Below 125% poverty	48.2	55.7	62.5	66.8	68.3	71.0	58.4	62.1	68.0	69.3	58.6	67.3
BLACK FEMALE												
In families	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	22.6	23.6	24.9	25.5	24.3	22.9	23.7	24.3	24.6	23.7	24.1	25.1
Below 125% poverty	31.1	34.1	36.4	37.1	36.3	35.6	34.1	35.5	36.5	36.0	35.0	36.8
Living alone	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Below poverty	54.4	56.5	60.7	64.4	67.4	72.7	60.2	61.8	66.7	69.5	58.4	65.4
Below 125% poverty	63.7	70.9	76.1	80.1	82.8	85.7	74.0	76.8	81.9	83.9	73.4	81.0

Source: Special Tabulations from the 1980 Census.

Table 4. Median Net Worth, by Age of Householder and Monthly Household Income

(Excludes group quarters)

Monthly household income	Total	Less than 35 years	35 to 44 years	45 to 54 years	55 to 64 years	65 years and over: Total	65 to 69 years	70 to 74 years	75 years and over
All households . . . . . (thousands) . .	86,790	25,730	17,393	12,596	12,920	18,151	5,668	5,014	7,468
Median income	$ 1,677	$ 1,596	$ 2,238	$ 2,381	$ 1,822	$ 1,021	$ 1,306	$ 1,022	$ 828
Median net worth	32,667	5,764	35,581	56,791	73,664	60,266	66,621	60,573	55,178
Excluding home equity	7,783	2,968	7,667	12,666	22,073	18,790	21,502	18,455	17,025
Net worth by income of—									
Less than $900:									
Households . . . . . . (thousands) . .	22,297	6,973	2,775	1,864	2,751	7,934	1,702	2,167	4,064
Median net worth	$ 5,080	$ 855	$ 2,147	$ 6,662	$ 23,587	$ 25,863	$ 23,257	$ 23,578	$ 28,986
Excluding home equity	1,386	626	683	869	2,470	3,727	2,468	3,488	4,634
$900 to $1,999:									
Households . . . . . . (thousands) . .	26,599	8,916	4,305	2,842	3,866	6,672	2,428	1,933	2,310
Median net worth	$ 24,647	$ 4,686	$16,533	$ 28,718	$ 60,232	$ 74,776	$ 68,509	$ 75,188	$ 80,044
Excluding home equity	6,329	2,531	3,690	5,281	14,983	29,849	22,412	27,718	41,343
$2,000 to $3,999:									
Households . . . . . . (thousands) . .	27,173	8,150	7,233	4,851	4,137	2,802	1,185	696	921
Median net worth	$ 46,744	$15,343	$44,421	$ 63,236	$ 88,464	$162,900	$151,450	$164,048	$175,949
Excluding home equity	11,437	8,661	9,426	13,144	30,462	80,327	73,618	81,060	97,146
$4,000 or more:									
Households . . . . . . (thousands) . .	10,720	1,691	3,081	3,039	2,168	743	354	217	172
Median net worth	$123,474	$44,424	$92,713	$138,961	$197,603	$344,518	$247,105	$410,252	(B)
Excluding home equity	44,860	18,158	32,907	45,740	88,437	212,710	166,751	268,515	(B)

B Base is less than 200,000.

Table 5. Distribution of Net Worth, by Age of Householder and Asset Type

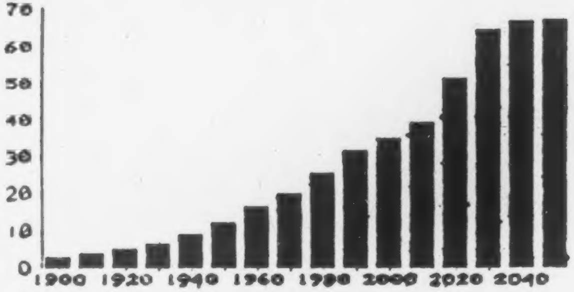
(Excludes group quarters)

Type of asset	Total	Less than 35 years	35 to 44 years	45 to 54 years	55 to 64 years	65 years and over
Total net worth	100.0	100.0	100.0	100.0	100.0	100.0
Interest-earning assets at financial institutions	14.4	11.6	8.3	9.3	13.4	24.8
Other interest earning assets	3.1	1.6	2.3	1.7	3.7	4.9
Checking accounts	0.6	1.2	0.7	0.6	0.4	0.6
Stocks and mutual fund shares	8.8	5.2	5.3	4.7	8.9	8.6
Own home	41.3	46.0	47.0	42.3	41.1	38.6
Rental property	9.0	5.3	7.8	11.0	10.9	8.2
Other real estate	4.4	4.5	4.9	5.1	5.2	3.0
Motor vehicles	6.0	16.6	7.4	6.0	4.6	3.4
Business or profession	10.3	17.4	14.1	16.0	7.9	4.5
U.S. saving bonds	0.5	0.3	0.2	0.4	0.6	0.8
IRA or KEOGH accounts	2.2	1.6	2.0	2.8	3.3	2.6

Source

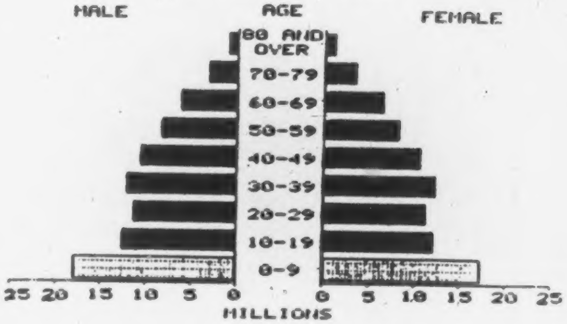
U.S. Bureau of the Census, Current Population Reports, P-70, No. 7, Household Wealth and Asset Ownership: 1984.

Chart 1



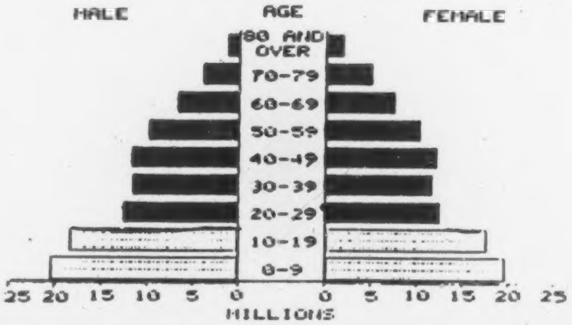
POPULATION 65 YEARS AND OVER: 1900-2050
(IN MILLIONS)

Chart 2



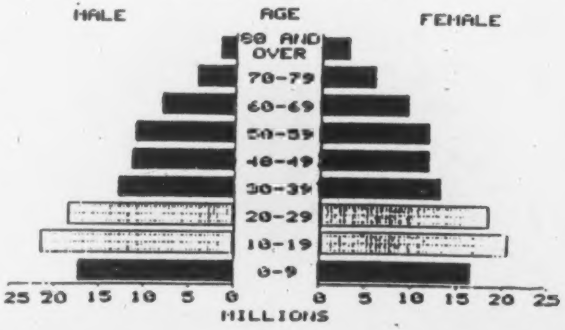
POPULATION: 1955

Chart 3



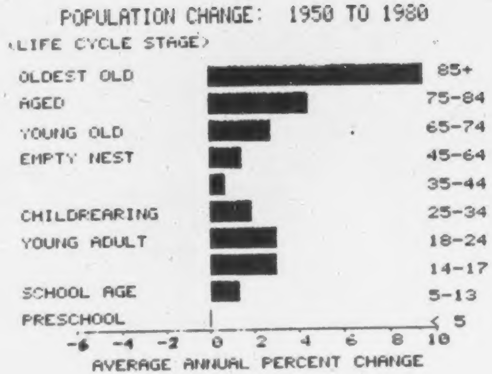
POPULATION: 1965

Chart 4



POPULATION: 1975

Chart 5



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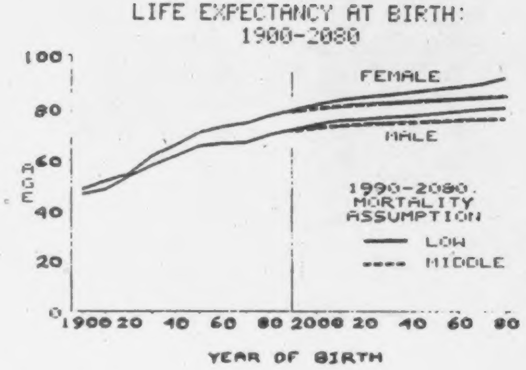


Chart 7

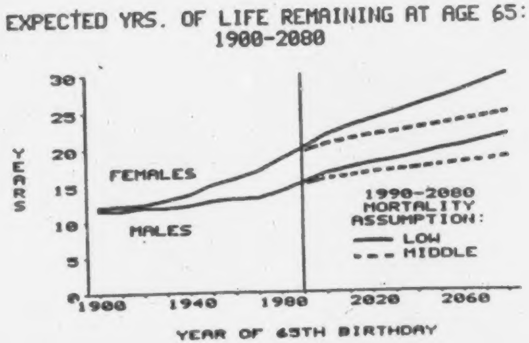
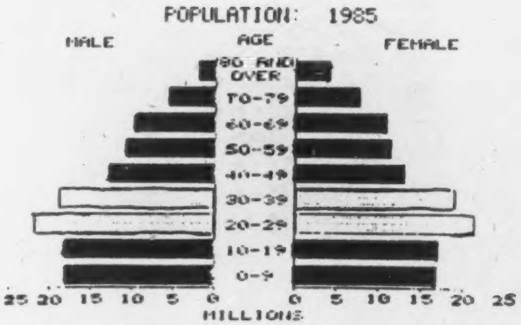


Chart 8



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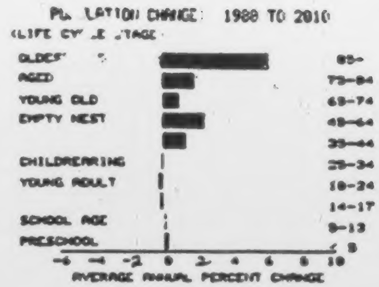
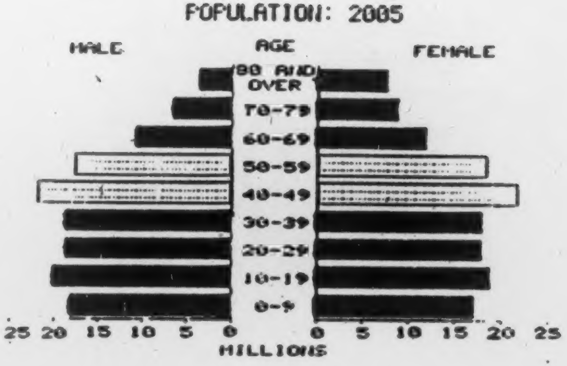


Chart 10



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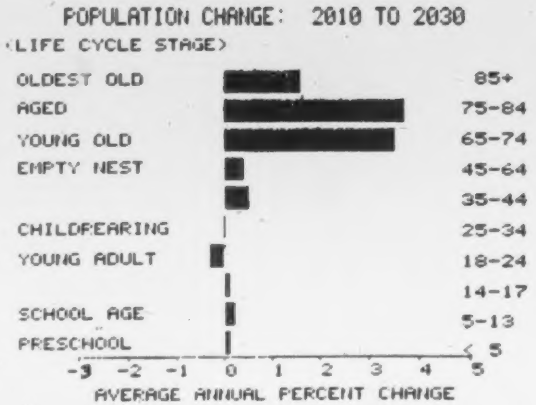

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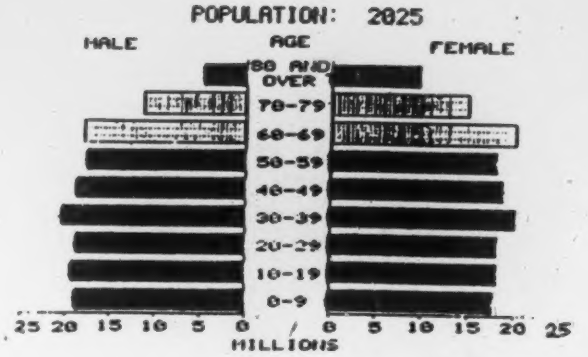


Chart 13

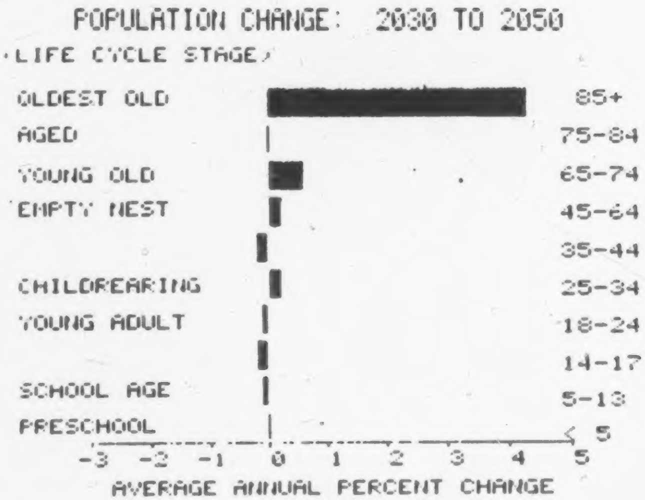
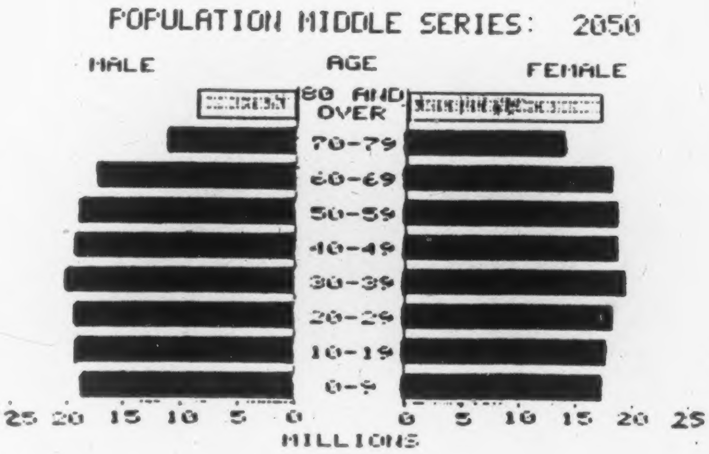


Chart 14



Poverty Status in 1979

Chart 15

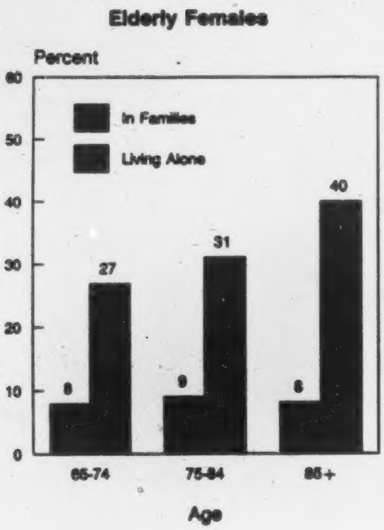


Chart 16

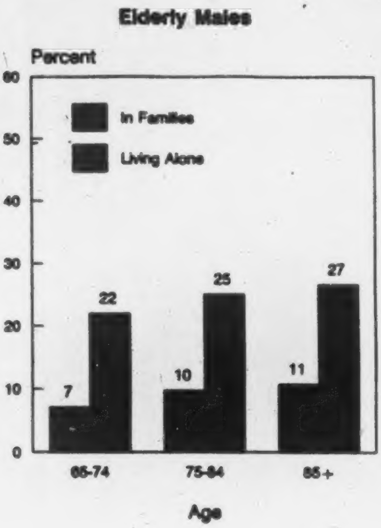


Chart 17

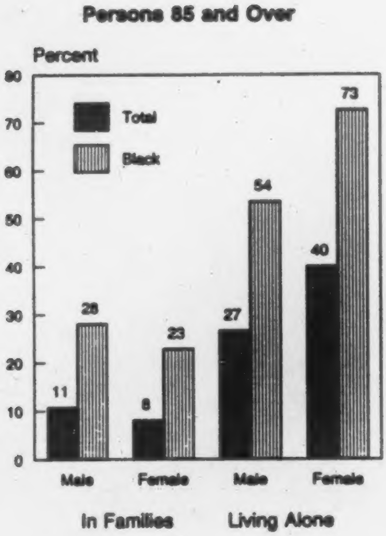
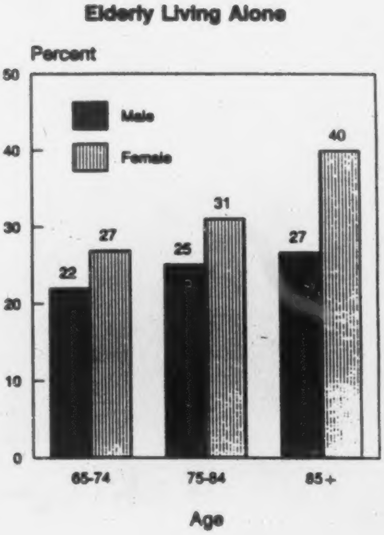


Chart 18



Reproduced from Aging America: trends and projections. Prepared by the U.S. Senate Special Committee on the Aging in conjunction with the American Association of Retired Persons, the Federal Council on the Aging, and the U.S. Administration on Aging. 1987-88 edition [Washington] U.S. Dept. of Health and Human Services, [1988] p. 1-5.

Introduction

America is growing older. One of the most significant demographic facts affecting America's present and future course is the aging of its population. The number of persons age 65 and older is growing more rapidly than the rest of the population.

A quick overview of this surge in the older population highlights such facts as:

Growth

—In 1900, one in ten Americans was age 55 and over and one in 25 was age 65 and over. By 1986, one in five was at least 55 years old and one in eight was at least 65.

—The older population grew more than twice as fast as the rest of the population during the last two decades.

—The median age of the U.S. population is projected to rise from 31.8 today to 36 by the year 2000 and to 42 by 2040.

—The 85-plus population is growing especially rapidly. This population group is expected to be seven times as large by the middle of the next century as it was in 1980.

—The elderly population is growing older. In 1986, 41 percent of the elderly population was age 75 and older. By the year 2000, half of the elderly population is projected to be 75-plus.

—Elderly women now outnumber elderly men three to two. This disparity is even higher at age 85 and older, when there are only 40 men for every 100 women.

—The ratio of elderly persons to persons of working age has grown from seven elderly per 100 persons age 18 to 64 in 1900 to 19 per 100 today. By 2010, there are expected to be 22 elderly persons per 100 of working age and by 2050, 38 per 100.

—Life expectancy at birth improved dramatically over the last century. Individuals born today have a life expectancy 27 years longer than those born in 1900. In 1985, life expectancy at birth for women was 78.2 years, while for men it was 71.2 years.

—The number and proportion of older veterans is increasing. By the year 2000, close to two-thirds, 63 percent, of all 65-plus males will be veterans, compared to a little over one-fourth, or 27 percent in 1980.

—More than half of the elderly live in just eight states: California, New York, Florida, Pennsylvania, Texas, Illinois, Ohio, and Michigan.

—In 1980, for the first time, more elderly lived in the suburbs than in the central cities.

—On average, older persons change residences one-fourth as often as younger persons, but those who move out-of-state tend to move to the Sunbelt.

—A new trend, called "countermigration," has emerged in which some 60-plus persons who migrated to the Sunbelt in their early retirement years return to their home states or the homes of family and friends.

Economic Status

- Older persons have substantially less cash income than those under 65. In 1986, the median family income of a family head age 65 or older was less than two-thirds (62 percent) the median income of a family head age 25 to 64.
- Elderly persons are more likely than other adults to be poor. (However, when children are also considered, elderly poverty rates are slightly below poverty rates for the rest of the population.) In 1986, 12.4 percent of persons 65 and older had incomes below the poverty level, compared to 10.8 percent of those age 18 to 64 and 13.7 percent of all persons under age 65.
- The old-old (85 years of age or older) have significantly lower money incomes than the young-old (65 to 74 years of age). In 1985, the median cash income of couples age 85 and over ($15,111) was less than three-quarters the median cash incomes of couples age 65 to 74 ($20,354).
- In 1986, the median income of elderly women was slightly more than half (56 percent) the median income of elderly men, $6,425 versus $11,544. Nearly three-quarters (71.8 percent) of the elderly poor population are women.
- Nonwhite elderly individuals have substantially lower money incomes than their white counterparts. For instance, among those age 65 to 69, white males had a median income in 1986 of $14,041 compared to a median of $7,078 for black men and $8,083 for Hispanic men.
- The elderly rely heavily on Social Security benefits and asset income. In 1984, 38 percent of all income received by aged units came from Social Security and 28 percent from assets.
- While Social Security and assets have grown in recent decades as a source of income for the elderly, earnings have become less important. Between 1968 and 1985, the share of income for elderly families provided by Social Security grew from 23 to 32 percent of income and the share provided by asset income grew from 15 to 23 percent. At the same time, the share contributed by earnings fell from 48 to 29 percent.

Retirement Trends and Labor Force Participation

- In this century, retirement has become an expected part of an individual's life course. In 1900, the average male spent three percent of his lifetime in retirement. In 1980, he was spending nearly one-fifth, or 13.8 years of his life in retirement.
- Age 65 is commonly thought of as the "normal" retirement age. However, almost two-thirds of older workers retire before age 65.
- The labor force participation of men and women drops rapidly with increasing age. For instance, according to labor force statistics for 1986, 55 percent of 60- to 64-year-old men were in the labor force compared to 25 percent of 65- to 69-year-old men, and ten percent of those age 70-plus.

—In 1986, almost three-quarters (72 percent) of 65-plus workers were in managerial and professional; technical, sales, and administrative support; and service occupations.

—Three-quarters of the labor force would prefer to continue some kind of part-time work after retirement. In 1986, of the elderly who were at work in non-agricultural industries, 48 percent of the men and 61 percent of the women were on part-time schedules.

—For those elderly who desire to work, unemployment creates serious problems. Older workers who lose their jobs stay unemployed longer than younger workers, suffer a greater earnings loss, and are more likely to give up looking for another job.

Health Status and Health Services Utilization

—Contrary to stereotype, most older persons view their health positively. Although most older people have at least one chronic condition, seven out of ten noninstitutionalized elderly describe their health as good or excellent compared to others their age.

—One out of four elderly have at least a mild degree of functional disability, but the chance of becoming disabled increases with age. Half of the oldest-old have some functional disability.

—Cross-sectional data have shown that the likelihood of having a chronic illness increases with age. More than four out of five persons 65 and over have at least one chronic condition and multiple conditions are commonplace among the elderly.

—Many psychiatric problems are not as common for older persons as for younger persons. However, an important health problem of older age is cognitive impairment (which can be related to a number of sources, including Alzheimer's disease). A recent study has shown that 63 percent of the elderly in nursing homes have at least a mild form of cognitive impairment.

—Three out of four elderly die from heart disease, cancer, or stroke. Though heart disease has been declining, it remains the major cause of death today.

—The elderly are the heaviest users of health services. They account for 30 percent of all hospital discharges, 20 percent of all doctor visits, and one-third of the country's personal health care expenditures even though they constitute only 12 percent of the population. Health care use is greatest in the last year of life and among the old-old.

—Only about five percent of the elderly live in nursing homes at any given time. In 1985, an estimated 1.3 million elderly persons lived in nursing homes.

—"Informal supports"—the help of friends, spouses, and other relatives—provide valuable assistance to the elderly. For instance, in 1982, relatives represented 84 percent of all caregivers and provided 89 percent of all days of care for disabled elderly men living in the community.

—Out-of-pocket health expenses for the elderly are now the same as they were prior to the enactment of Medicare and Medicaid. In 1984, the average out-of-pocket expenses of the elderly were $1,059 annually, or 15 percent of their income.

—Per capita spending from all sources for health care for the elderly was $4,202 in 1984.

Social Characteristics

—Most elderly men are married and live in a family setting, while most older women are widows. In 1986, 67 percent of women age 75-plus were widowed while 68 percent of the men in this age group were married. In 1986, 51 percent of women age 75-plus lived alone, while only 19 percent of men in this age category lived alone.

—The gap in educational attainment between the elderly and nonelderly is closing. In 1986, elderly people had completed an average of 11.8 years of school compared to 12.6 years for all adults.

—In 1985, 75 percent of the households maintained by an older person were owner-occupied and about 83 percent of these were owned free and clear.

—The elderly increasingly tend to rent rather than own as they grow older.

—The elderly are most likely to live in older homes. In 1983, 36 percent of elderly owners lived in homes built before 1940, and 13 percent lived in structures built between 1940 and 1949.

—Significant numbers of elderly persons live in inadequate housing and do not have telephones. In 1983, one out of ten elderly housing units were classified as inadequate because of flaws in plumbing, kitchen facilities, electrical systems, or other structural or operating characteristics. Nine percent of older renters and three percent of older homeowners in 1980 did not have telephones.

—Age groups 55 and older are the most likely age groups to vote. Data for the 1980, 1982, 1984, and 1986 elections demonstrate that about one-third of all voters are age 55 or older.

—One of every five older people in 1984 used one or more of a selected group of services provided in the community. The services included senior centers, meals programs, transportation, visiting nurses, and others.

Federal Expenditures on the Elderly

—Federal spending on the elderly has nearly doubled since 1960. In 1986, $270 billion or 26 percent of the federal budget was of direct benefit to older Americans. About 81 percent of this amount was for Social Security, Medicare, or Medicaid benefits.

—In the future, rising health care costs will gradually overtake federal spending for retirement income as the source of greatest increase in federal spending on the elderly. Federal expenditures for health care are projected to increase from three percent of GNP in 1986 to more than six percent in 2030, while federal expenditures for pension programs will hold steady at about seven percent.

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ABSTRACT

Due to the many definitions and perceptions of the aging process, some generally agreed upon definitions and perceptions of aging are elucidated in this paper. These definitions and perceptions are discussed with a focus on the sociological, biological, and psychological components involved in the normal aging process. The current and projected demographics of the elderly population are discussed along with some challenges our society may encounter in dealing with dramatic increases in the elderly population. This paper concludes with some current research efforts.

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SUMMARY

The scientific examination of aging and the aging process is a relatively new area of public interest and concern. One of the first concerns is establishing acceptable and working definitions and appropriate perceptions of the aging process. In aging an individual can progress from one stage of development to another without necessarily developing diseases and serious medical problems along the way. The process of aging may also be defined as change in one's physical, social, and mental status over time. Aging is characterized by biological, psychological, and sociological changes. Many researchers on aging contend that one's physical health, personality, and intelligence can and often do remain relatively unaffected by the aging process providing the stress levels remain somewhat constant and manageable.

In order to assess the health status in the elderly population, it is important to use a concept of health that is flexible enough to describe newly emerging patterns. For example, most elderly Americans are active and independent in spite of suffering from one or more chronic conditions. Results from current research show that persons between the ages of 65 to 74, in general, have a health profile more like those of persons aged 45 to 64 than of persons aged 75 and older.[1] Other studies show that slightly more than 80 percent of the population aged 75 to 84 and more than 50 percent of the over 85 age group are independent in accomplishing the activities of daily living (i.e., dressing, eating, bathing, etc.). At least one-half of the elderly population at age 80 shows no noticeable signs of decline in cognitive function.[2]

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[1] U.S. Congress. Senate. Special Committee on Aging. Health and Extended Worklife, Feb. 1985. p. 2.

Most research on aging suggests that until the elderly reach their eighties, functional impairments are not a result of aging, but rather due to pathology (disease condition).[3] As the population of the U.S. grows older, we can anticipate a much larger population of generally healthy aging individuals who will experience more meaningful and productive lives. It seems apparent that life styles and patterns of health care are important determinants of the health status in the elderly population. Although the general health status of the elderly population is improving, this population is still at increased risk of developing multiple chronic conditions along with the development of adverse reactions to drugs during treatment for these conditions. This is a major area of concern because of the disproportionately high prescription and over-the-counter drug consumption this age group. This has in addition to serious medical implications, also serious economic concerns. Currently, the elderly population consumes roughly 25-27 percent of all drugs, which amounts to about $3 billion annually.

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[2] Katz, Sidney, et al. Active Life Expectancy: Social Implications. America's Aging: Health in An Older Society. Institute on Medicine/National Research Council. National Academy Press, Washington, D.C. 1985. p. 10.

[3] Somer, Anne R. Financing Long Term Care for the Elderly: Institutions, Incentives, Issues. America's Aging: Health in An Older Society. Institute of Medicine/National Research Council. National Academy Press, Washington, D.C., 1985.

AGING: HEALTH EFFECTS AND BEHAVIOR

INTRODUCTION

The United States, like most developed countries, is facing an unprecedented growth in its elderly population. In the last few decades, the elderly population has grown almost twice as fast as all other age groups. This rapid increase in the older population has presented significant challenges to the Congress and Federal Government in developing health, research, economic, and social policies.

One of the major challenges in actively coping with the implications of the aging population is to gain an informed perspective on normal or successful aging, general state of the health in the older population, and diseased conditions in this age group. An additional challenge is to establish a relationship among the three parameters listed above. One of the difficulties in obtaining an understanding of the elderly is that this population is very diverse in physical, behavioral, social, emotional, economic, and political characteristics. The health status of the elderly appears to be related to the full course of their life experiences from youth through adult years. A clearer understanding of the heterogeneity of the elderly population should raise new issues and help resolve others concerning aging and health and societal responsibilities toward older persons. It is hoped that from resolution of these issues, a series of policies will evolve as well a framework for more effective policy responses.

GENERAL CHARACTERISTICS

In recent years, the elderly population has increased at a rate more rapid than the rest of the population. In the last twenty years the population of those over 65 years of age increased by 54 percent while the under-65 population increased by only 24 percent. It has been further estimated that during the last two decades, an average of approximately 150,000 Americans joined the ranks of the elderly each month.[4]

The U.S. population of elderly has doubled during this century. At the beginning of the century, 1 in 25 was over age 65. By 1984, 1 in 9 was over 65. Data published in 1984 by the U.S. Census Bureau showed that there are 50.2 million Americans age 55 or older and 28 million who are 55 to 64 years old. About 9 percent (22.2 million) of the total population was 55 to 64 years old, 7 percent (16.6 million) was 65 to 74 years old, 4 percent (8.8 million) was 75 to 84 years old, and 1 percent (2.6 million) was 85 or older. About 32,000 persons were 100 or older; roughly 60 percent of this group was female.

It is commonly assumed that today's large numbers and proportion of older people are caused primarily by increased longevity. However, the rise in longevity explains only part of this increase. The primary causes were an increase the annual number of births prior to 1920 and also following World War II and large scale immigration in the early decades of this century. Aging of the pre-1920s groups along with a dramatic decrease in the birth rate in the 1930s and after the mid-1960s have contributed to the rise in the median age from 28 in 1970 to 32 in 1984.

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[4] An Aging Society. America in Transition. Current Population Reports. Special Studies Services, no. 128. p. 23.

It is projected that the growth rate in the elderly population will raise the median age of the U.S. population from 32 today to 36 by the year 2000 and to age 42 by the year 2050. It is further projected that the total U.S. population will increase by a third between 1984 and 2050, while the 55-plus population is expected to more than double during this period. If current fertility and immigration levels remain stable, the only age groups that may experience any significant growth in the next century will be those past 55 years old. Demographers project that the increase in the older population will occur in two stages. First, the 55 and over age group is expected to remain constant at just over one in five (22 percent) through year 2000. Then, by 2010, the proportion of older Americans will rise dramatically when more than one-fourth of the total U.S. population is expected to be at least 55 years old and one in seven Americans will be at least 65 years old. By 2050, one in three is expected to be 55 years or older and one in five will be 65-plus.[5] [6]

Current knowledge reveals no precise, universally agreed upon definition of the aging process. However, some definitions and perceptions, as viewed by some physiologists, psychologists and sociologists, are discussed below.

Aging may be defined as the process of change in one's physical, social, and mental status over time. More specifically, it is a complex interaction of the physical, mental, social, spiritual, and intellectual dimensions of each human being. It is an experience that is characterized by biological, psychological, and sociological changes. The biological aging process usually denotes an individual's relative position in terms of his or her life span. It involves the physiological (body functions) changes that occur during the aging process. In some cases, it is difficult to determine whether physiological change is the result of internal factors, such as genetic predisposition to diabetes or the graying of hair, or whether the physical change results from external factors, such as stress, disease or simply poor nutrition. Currently there are no reliable methods to measure precisely biological aging. However, it is often related to chronological aging.

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[5] Weeks, John R. Aging: Concepts and Social Issues. Wadsworth Publishing Company, A Division of Wadsworth, Inc., Belmont, CA, 1984. p. 37-64.

[6] Siegel, Jacob S. and Maria Davidson. Demographic and Socioeconomic Status of Aging in the United States. U.S. Bureaus of the Census, Current Population Report, 1984. Series p. 25, no. 138.

Psychological aging refers to one's capacity to adapt to both familiar and unfamiliar situations. This component of the aging process is most often measured by observing the behavior of an individual as she/he adapts and adjusts to these situations. Comparisons are then made of the individual's behavior with what has been established as a typical or normal behavioral pattern for that age group. For example, young children can be expected to be self-centered, desire immediate attention to their needs, and eventually have a desire to succeed. Typically, one can expect the adolescent to display sudden changes in mood and to be self-critical. Young adults tend to be more sensitive to the economic and social status of the family. In later years older adults are more conscious of feelings such as: friendliness, happiness, satisfaction, and occasionally discouragement and guilt. All of these feelings and perhaps many others are generally considered to be normal for each age group. Psychological aging, then, is related to some extent to chronological age.

Sociological aging denotes the performance of prescribed social roles at given ages. This type of aging is usually measured by developing a composite list of one's performance of specific social roles at specific ages. A comparison may then be made with established social developmental patterns.

For example, children begin developing social skills by learning to cooperate, working in groups, and belonging to a group. Adolescents are influenced by the peer group, they are socially insecure, and most become interested in the opposite sex. In early adulthood a family pattern and career are established and social and political groups are identified. As time passes, careers reach a peak, parents become grandparents, both men and women become widowed, and age usually requires retirement from a lifelong career. These are examples of specific social roles that are generally performed at specific times in the aging process. Sociological aging appears to be closely related to chronological aging and to a lesser degree to psychological aging.

In general, we perceive the aging process within our own frames of reference based upon our experiences with other people and upon their ethnicity, economic status, and occupation. Each generation perceives the preceding generation to be old, but the degree to which the perception is positive or negative depends upon the older people with whom we interact. For example, if the interactions take place exclusively with older people who are always ill or in poor health, it is quite likely that the perception that develops will be that old means being sick. If, however, there is interaction among all types of people, more alternatives are presented from which a different perception may be developed.[7]

INTRINSIC AGING COMPONENTS

Internal or intrinsic aspects of aging are based upon physiological and biological factors that influence one's potential longevity. These factors include such things as genetic makeup, family longevity patterns, personality, sex and race, and intelligence. One has little or no control over these intrinsic components of aging.

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[7] Neugarten, B., R. Hauighurst, and S. Tobin. Personality and Patterns of Aging. In B. Neugarten (ed.) Middle Age and Aging. Chicago University, 1985.

It is commonly believed by researchers on aging that maximum longevity is determined at the moment of conception.[8] The genetic blueprint received from one's parents influences potential height, hair and eye color, sex, size of nose, and many other characteristics. This genetic blueprint also may contain in its design the maximum length of an individual's life span. Factors like accidents and poor health habits obviously can shorten one's life span.

Because it is currently impossible to examine an individual's genetic blueprint for purposes of estimating longevity, it is necessary to rely on studies of inherited life span by examining such information as genealogical records, life insurance records, and family histories of the general population. In general, it may be stated that children of long-lived parents are likely to live longer than children of short-lived parents.[9]

EXTRINSIC AGING COMPONENTS

Extrinsic or environmental components related to aging include such things as employment and economic level, health practices and diseases, education, and societal attitude. In most cases, one has some degree of control over these factors and they all influence, in varying degrees, the total aging process. For example, one's lifestyle is determined largely by employment and income.

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[8] Palmore, E., and E. Jeffers. Predictions of Life Span. Lexington, KY., Heath Lexington Books, 1971.

[9] Wantz, Molly S. and John E. Gay. The Aging Process: A Health Perspective. Winthrop Publishers, Inc., Cambridge, MA., 1981. p. 9-24.

The type of health care one receives as well as the type of food one eats are mainly dependent upon the amount of money that is available up to a point.

Components such as poor living conditions, inadequate diet, and job-related and financial stress have an impact on the overall level of health and well-being of an individual. These factors may increase an individual's susceptibility to disease that shorten the potential life span.[10]

PRACTICAL MEDICAL PROBLEMS

As our bodies change with advancing age, is it necessarily true that we become less healthy? To address this issue, this section will examine the incidence of acute and chronic diseases among the elderly compared to younger people.

An acute disease is usually defined as one that affects us for a relatively short period of time (in most cases lasting less than three months) and is severe enough to require medical attention or to restrict normal activity for at lease one day. These diseases can range from a mild virus (the common cold, for example) to a severe, potentially fatal disease such as typhoid fever. The common assumption that increasing age automatically increases the frequency of acute disease is erroneous. Results from studies using the National Health Interview Survey show people aged 65 and older in the United States are actually less than half as likely to be struck by an acute disease as are people aged 17-44. However, the data also show that older people are more intensely affected than younger people when an acute condition does strike. The average number of days per year of restricted activity due to acute conditions is nearly three times greater for people aged 65 and older than for ages 17-44. Further comparison shows that the average older person gets sick once a year, is confined to bed 4.5 days during that illness and has normal activities curtailed for about 11 days. In contrast, a younger person is afflicted more than twice a year but spends less than 2 days in bed and restricts activity for only 4 days.[11]

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[10] Ibid.

One reason for the greater impact of acute diseases on the elderly is that they are more likely than younger people to be afflicted by a chronic ailment that may aggravate recovery from acute disease. A chronic ailment usually has a duration of more than 3 months and is commonly recognized as being long-term, and in some cases, an incurable condition. Chronic ailments include conditions such as arthritis, and physical conditions such as varicose veins. Table 1 lists the 10 most prevalent chronic conditions in the United States by age of victim. Arthritis, for example, is the most common condition for those age 45-64. Overall, about 44 percent of all older people are afflicted by arthritis, and this rate is roughly 9 times higher than for people age 17-44, as indicated in the far right column of table 1. Only arteriosclerosis increases more rapidly with age than does arthritis. Clearly, some of the chronic conditions listed in table 1, such as frequent constipation, are much less serious than others, such as diabetes, but they all go into the equation of how healthy we are. Most physical impairments are more prevalent in old age than in the younger years. For example, hearing impairments are among the more common disabilities at ages 65 and older, followed by vision problems, impairment of the lower extremities or hip, paralysis, speech, and the absence of major limbs. As is true with chronic diseases, the seriousness of individual impairments range from slightly bothersome to totally disabling.

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[11] MacLennan, W. J., A. N. Shepard, and I. H. Stevenson. The Elderly. Springer--Verlag, Berlin. Heidelberg, New York, Tokyo, 1985. p. 11-28.

TABLE 1. Chronic Diseases are More Prevalent Among the Elderly

The Ten Most Common Chronic Diseases	Rate per 1,000 persons by age: 17-44	45-64	65+	Ratio 65+ to 17-44
1. Arthritis	47.8	252.7	442.7	9.2
2. Cerebrovascular disease	58.8	214.4	385.1	6.5
3. Hypertensive disease	37.5	128.5	274.4	7.2
4. Chronic sinusitis	148.4	189.2	156.1	1.0
5. Arteriosclerosis	0.8	21.6	123.5	154.0
6. Varicose veins	18.6	51.3	89.4	4.7
7. Diabetes	8.7	57.9	79.7	8.9
8. Hemorrhoids	48.5	64.7	66.1	1.3
9. Frequent constipation	11.1	26.8	63.9	5.8
10. Hernia of abdominal cavity	8.2	38.7	62.6	7.9

SOURCE: S. Jack and P. Ries. Current Estimates from the National Interview Health Survey, 1979. Data from the National Health Survey, Series 10, no. 136. Table 22.

Of particular interest is the fact that disability rates in the United States, for some types of impairments, have been increasing over time rather than decreasing as would be expected. Table 2 shows a major rise in the rate of both hearing and visual impairments between 1963 and 1977. This does not appear to be related simply to the aging process, because rates went up for people aged 45-64 just as they did for those 65 and older; furthermore, rates increased across the board regardless of sex and ethnicity. While it is not absolutely clear why this is the case, one of the more likely explanations is that increasing access to the health care delivery system occurred during that

TABLE 2. The Prevalence of Impairments Increases with Age and has Increased Over Time

	Prevalence of Impairment Rates Per 1,000 Persons Aged:				
	17-44	45-64		65+	
	1977	1977	1963-64	1977	1963-64
Impairment					
Visual	33	68	40	220	146
Hearing	40	124	71	309	216
Speech	6	7	n/a	10	n/a
Paralysis	4	11	11	26	27
Absence of major extremities	1*	3	n/a	6	5
Orthopedic impairments of lower extremity of hip	29	44	n/a	75	75

SOURCE: Feller, B. Prevalence of Selected Impairments, 1977. Data from the National Health Survey, series 10, no. 134. Tables 1, 4, 5, 6, 7, and 11 (1981). p. A. Jackson, Prevalence of Selected Impairments, July 1963--June 1983. Data from the National Health Survey, Series 10, no. 48. Tables 1, 2, 10, 22, 29. 1968.

period and the likelihood of a diagnosis therefore also increased. This interpretation seems most likely because some of the more obvious categories of impairment, such as paralysis or absence of major extremities, have not shown commensurate increases.

DRUG USE AND REACTION IN THE ELDERLY

In the last ten years interest in clinical pharmacology of old age has markedly increased. This new interest in the elderly has arisen for many reasons. These include the considerable growth in the older population, their disproportionately high prescription and over-the-counter drug use, and most importantly, the increased incidence of adverse drug effects in this age group.

In addition to constituting an increasing population, the elderly consume more drugs than younger age groups and consequently drug use by this age group is of considerable economic as well as medical importance. For example, in the United States in 1976, the 10 percent of the population who were elderly accounted for more than 20 percent of the total national drug bill. Currently, the roughly 12 percent of elderly in the population consumes 12-27 percent of all drugs. This translates to about $3 billion per year.[12]

Recent studies have shown that the elderly are more at risk of developing adverse drug reactions, a finding perhaps not unexpected in view of the multiple pathology (disease) occurring in this age group and the frequent need to use several drugs concurrently.[13]

With some drugs, the incidence of adverse reactions has been observed to increase with age. For example, a study conducted by the Boston Collaborative Drug Surveillance Program showed a clear relationship between age and adverse effects of heparin (a drug to prevent blood clotting) and several benzodiazepines. These drugs produce mainly unwanted central nervous system depression and the effects are clearly dose-related; the age-related trend appears to be absent at lower doses. Further, the majority of adverse reactions occur within the first 3 days of commencing therapy. For heart drugs, however, it was found that there is a relatively weak association between age and clinical toxicity.

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[12] Vestal, R. E. Majority of Elderly Use Medications. U.S. Medicine, Aug. 1, 1984.

[13] MacLennan, W. J., A. N. Shepard, and S. Tobin. The Elderly. Springer-Verlag, Berlin. Heidelberg, New York, Tokyo, 1984.

Different patterns of adverse drug reactions occur outside the hospital because additional factors become involved, such as the misuse of drugs by the elderly through noncompliance (in this context, compliance is not simply failure to take medications; it also includes consuming foods or other drugs that may be incompatible with the current drug regimen and not following the prescribed dosage or dosage instructions). When the large number of drugs prescribed for the elderly is considered in combination with their increased susceptibility to adverse drug reactions, analysis has shown that probably more than half of all unwanted drug effects in fact occur among geriatric patients.[14] [15]

INDIVIDUAL REACTIONS TO THE AGING PROCESS

Many studies have shown from in-depth interviews with the elderly that there is a wide range of "typical" behavior patterns in growing old, ranging from social disengagement to normal social activity, and several levels in-between. Eight patterns were distinguished in all: reorganizers (the ability to reconstruct or start over again), focused (attention on most important issues and problems), disengaged (withdrawal from active involvement in the social world), holding on (perseverance in difficult circumstances), constricted (narrowing of activities involving others), succorance-seekers, (dependency on others), apathetic (lack of concern about life in general), and disorganized (no orderly approach to life situations).

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[14] Eraker, S. A., J. P. Kirscht, M. H. Becker. Understanding and Improving Patient Compliance. Ann Intern Medicine, v. 100, 1984. p. 258.

[15] Hulka, B. S. et al. Communication, Compliance, and Concordance between Physicians and Patients with Prescribed Medications. American Journal of Public Health, v. 66, 1976. p. 847.

There is considerable evidence that, in most normal men and women, there is no noticeable change in personality with increasing age. It appears that those characteristics that have been central to the personality become even more clearly delineated, and at the same time those values the individual has been cherishing become even more salient. Age itself may be less important than we once believed; old age is but one phase of life, and an individual who is old cannot be understood completely unless one knows how he or she developed over the entire life-course. However, this is not to suggest that there is nothing about old age that is different from life at younger ages; old age has always been recognized as a unique part of the normal life-cycle. The life-cycle perspective merely alerts us to the fact that the attitudes and behavior of older people are fashioned, at least in part, by attitudes and behavior in younger years. This view implies that today's younger people are already developing in ways that will influence them as the elderly of the future. This indeed appears to be part of the socialization into old age, a process that often begins well before one reaches the later decades of life.

CURRENT RESEARCH EFFORTS

Research on aging may be obtained from longitudinal or cross-sectional studies and may be derived from sources that had aging as a major research emphasis or from studies in which data on aging may be obtained only incidentally. Although aging is generally considered to be a process, many researchers often are tempted (mainly because it is both easier and less costly) to study aging by comparing older to younger people at one point in time. Any noticeable behavioral differences between the age groups is attributed simply to differences in age in this approach. This approach is known as a cross-sectional or period analysis and usually produces useful distinctions among groups at a given time, but it does not identify changes in the course of a lifetime, since the researcher is not observing changes over time. Establishing causal relationships involves a longitudinal research approach that follows a cohort and/or panel of people through time repeatedly measuring variables, asking questions, and/or observing behavior. Researchers in aging recently have become increasingly conscious of the need for such longitudinal data, and a great deal of recent research reflects this concern, though the tremendous cost in time and money of following people for a number of years still limits the practice to only a handful of researchers who effectively employ longitudinal analyses. In order to maximize research benefits on aging, longitudinal studies focusing on the aging process seem to be a preferable approach over the cross-sectional studies with a non-aging emphasis.

One such study is the well-known Duke University Longitudinal Study on Aging. This study was initiated in 1954 to investigate the processes of aging among a panel of non-institutionalized males and females 60 years of age and over from the time of initial observation to death. Specifically, the study involved 270 persons who participated in a multidisciplinary longitudinal study on aging. The study investigated the relationship between self and physicians' assessment of general health that spanned 15 years. The results from this study showed that: there is a persistent, positive agreement of one's self and physician's ratings of health; when there is disagreement in ratings between physician and the elderly person, the tendency is for the elderly to overestimate, rather than underestimate their health status; substantial consistency of both self and physicians' ratings is observed through time, with the self health rating showing slightly more consistency; and an unexpected discovery is the tendency for the self health rating to be a better predictor of future physicians' rating than the reverse.[16]

In terms of biomedical and basic science research on aging, certain fundamental questions are now being pursued by researchers. These include:

1) Is aging a normally programmed process (controlled by genetic makeup)?;
2) Is there a "death gene"?; and
3) Are there alterations in cells such that each cell has a different reason for decreased function or death?

The possible answers to questions posed above may come from research efforts that will:

- depend on a basic knowledge of biology;
- use experimental animal systems that mimic human aging;
- study the neuroendocrine (genetic) area; and
- use modern techniques of molecular biology, and depend on the quality of questions asked.

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[16] Maddox, G. L. and E. B. Douglass. Self-Assessment of Health: A Longitudinal Study of Elderly Subjects. Journal of Health and Social Behavior, v. 14, Nov. 1 1973. p. 87-93.

Reproduced from U.S. Congress. Senate. Joint Economic Committee. Subcommittee on Economic Resources, Competitiveness, and Security Economics. Demographic changes in the United States: the economic and social consequences into the 21st century. Hearings, 99th Congress, 2nd session. Washington, G.P.O., 1987. p. 477-490. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-1088)

PREPARED STATEMENT OF GEORGE C. MYERS

THE GRAYING OF THE POPULATION: IMPLICATIONS FOR THE U.S.

Chairman and members of the Subcommittee on Economic Resources, Competitiveness, and Security Economics of the Joint Economic Committee, I wish to thank you for the opportunity to participate in today's inquiry into the long-term consequences of the aging of the American population. I am George C. Myers, Professor of Sociology and Director of the Center for Demographic Studies at Duke University. I am currently a member of the National Committee on Vital and Health Statistics and formerly have served on the Bureau of the Census Advisory Committee on Population Statistics and the National Institute on Aging's Review Committee.

In my presentation today, I would like to address some of the main demographic, social and economic changes that have accompanied the rise in the numbers and proportions of older persons in our population. In turn, I will indicate broader implications of these changes and some policy dimensions that are apt to be encountered by likely developments in the future.

DEMOGRAPHIC PERSPECTIVES

Demographers studying population aging bring together a number of perspectives that relate to our present considerations. For this presentation, I will make use of trends forecasted over the next 35 years in the numbers of persons in selected age categories of the population as shown in Figure 1 and additional population dimensions in Table 1. They provide an effective means of examining some principles about population aging. Several recent accounts of these developments are available for detailed study (Myers, 1985; Myers, Manton and Bacellar, 1986; Siegel and Taeuber, 1986).

- Interest in empirically establishing prior trends and preparing projections of future developments. This is of particular importance in the study of population aging for we can gauge the future size of the aged population with reasonable effectiveness, inasmuch as even those who will be aged in the middle of the next century have already been born. The *momentum* of future growth of the aged population is embedded in the size of birth groups in the past. Thus, the baby-boomers will make their entrance into the ranks of the aged after 2012. Figure 1 informs us, however, that the aged population will increase *throughout* the projection period -- even before the explosion occurs!
- Interest in the dynamic properties of population change. Studying the *metabolism* of the aged population involves assessment not only of new entrants — that is cohorts reaching older ages, but persons dying, and the changing characteristics of older persons, such as shifts in age, sex and other characteristics. Figure 1 indicates the changing numbers of persons aged 60-64 who are about to enter the older ages. Although this age group declines numerically up to the year 1995, an accelerated increase is found thereafter. Noteworthy, is the fact that the aged population 65 and over increases even more sharply, which indicates that mortality rate declines are expected to produce more older survivirs in the decades ahead. It may be noted that these dynamics of increment and decrement produce a uniquely high turnover for the aged population overall.
- Interest in the composition of population. The aged population is notably *diverse* and appears to be increasingly so. Diversity with respect to a whole range of characteristics — age, sex, race, ethnic

and racial status, marital status, educational status, socioeconomic status, etc. This comes about from the dynamics noted earlier -- new cohorts of older persons, selective mortality of those at older ages, and changing behaviors that affect modifiable characteristics. To take the most simple example, Figure 1 and Table 1 show the growth of the oldest-old population in numbers and as a percentage of the aged population itself. These oldest-old are increasingly being recognized as quite different from younger-old persons in their various health and social characteristics (Rosenwaike, 1985). Their increasing numbers contribute, therefore, to the growing heterogeneity of the aged population and emphasize the importance of acknowledging diversity in considering issues relating to the aged population.

- Interest in comparative analyses of different components of population at different points in time. Aged persons represent merely only one segment of a total population. We have pointed out how diversity exists within the aged population, but differences occur among different age groups of the total population in terms of both size and characteristics. In effect, consideration of an aging society takes into account not only growing proportions of older persons vis-a-vis other age categories, but also how the aged population differs in various respects at any one point in time and over time. Here we must emphasize both the cross-sectional comparisons as well as the comparisons of different birth cohorts as they age collectively over a life course. Comparing trends in the size of different age groups over time, as can be seen in Figure 1, or in the structural ratios (sometimes referred to as dependency ratios) presented in Table 1 provide the most elementary types of comparisons. For example, estimated growth trends of the population 65 years and over to youths 0 to 15 years bear evidence to the fact that parity in the size of these respective groups will be reached shortly after the year 2020. In terms of sex composition, the trends in Table 1 indicate the preponderence of females in different older age groups, but the trends also reveal a reversal can be anticipated in the future. That is, the sex ratio of males to females actually increases over time for age groups up to ages over 90.

IMPACT OF DEMOGRAPHIC CHANGE ON SOCIAL STRUCTURES OF AN AGING SOCIETY

Demographic changes provide an important basis for understanding of shifts in the social structures of a society through time. However, to fully understand these shifts, we also must consider the role of behavioral modifications and how they affect and are affected by the political, economic, and cultural institutions. Let us examine several examples of how these forces come into play.

Labor Force and Retirement

From a demographic point the size of labor force is affected by the net balance between entrants and exits through death and retirements. Simple projected trends in the size of the age categories 20-24 and 60-64 give us an approximation of the purely demographic factors, as shown in Figure 1. Of course, labor participation rates, particularly by sex, are a necessary addition for examining the size of the labor force. Holding these constant, however, we can see that the size of potential exits (persons 60-64) remains stable until the turn of the century, but then rises rapidly to the year 2020. The projected numbers of persons 20-24 fluctuate over the period, but remain fairly constant. However, a crossover between these age categories occurs between 2015 and 2020. From this perspective, the fears of a dwindling labor force are felt mainly in the long-term. Moreover, improved survival through the working ages may even increase the potential workers in the labor force.

Viewed more generally, these conclusions are in agreement with other more sophisticated national projections (For a review, see Myers et al., 1986) that indicate a growing labor force through the year 2020. Critical in these projections are assumptions that little reversal in early retirement for both men and women can be anticipated and perhaps even slightly lower levels of labor force participation for older men and women. In spite of recent Federal legislation and the seemingly improved physical capacity for employment, little support exists for the notion that current retirement trends will be attenuated at least in the short term. We may speculate that shifts in the nature of work toward less physically demanding occupations and the increasing social capital of future older workers may affect retirement behavior, but it seems unlikely that these factors relating to the ability to work will operate in the shorter-term. In any event, aged workers currently represent only a very small share of the labor force (1.1 percent in 1980) and even major changes would have only a modest impact on the labor force as a whole. Morever, continued employment after age 65, even with legislated increased social security credits for remaining employed appear to have only a small financial effect on the system. I will leave the main discussion of social security conditions to subsequent panelists.

Family Structure, Living Arrangements and Housing

These three societal conditions are closely interwoven. Changing family structures within a society are strongly influenced by demographic trends. Improvements in survival have increased the likelihood of reaching old age both individually and jointly with spouses. So too, it has affected "vertical" extension of multigenerational families, even those with older persons. Moreover, the possibility of having one or both parents alive for persons reaching old age has increased. One result of this increased longevity has been the trend toward higher proportions of both older men and women being in the married state, and reduced proportions of the aged who are widowed. This trend is found not only for the aged as a whole, but for all age groups up to the oldest-old. Older men remain much more likely to be married than women, however, due to both their lower changes of survival and their propensity to remarry. Thus, widowhood is a condition mainly experienced by women, but even widowhood has been postponed until later in life and its duration somewhat curtailed.

It has been noted that prevailing trends toward increased levels of divorce, separation, and remaining single are certain to have an effect on marital status distributions of older persons in the future, but these are unlikely to have a major impact in the short-term and are, in any case, mitigated by high levels of remarriage at younger ages, especially for men. This is not to minimize the potential implications of current trends, but to emphasize that their impact will be felt only well into the next century.

The living arrangements of older persons are influenced by marital status characteristics. American families have always tended to have independent nuclear family household arrangements, even at older ages. The predominant pattern among older persons remains the intact husband-wife household, with very little shift in the proportions of the total aged who experience this condition. Noteworthy however, has been the greatly increased likelihood of independent living for those older persons without a spouse. Concommitantly, the proprotions of older persons living with related persons, including siblings or unrelated persons, have declined, especially for women. The proprotions living in group quarters and institutionalized remain relatively insignificant (less than 7 percent).

These trends are difficult to explain without due consideration of the strong desire of older persons to maintain their independence as long as they possess the health and resources (financial and social supports, both informal and formal) to do so effectively. Certainly, adequate maintenance of income, as afforded by social security benefits and private pensions, for example, have played a strong role in this regard. Projections of future living arrangements generally have assumed that current conditions will persist into the future. They typically reveal very little in the way of major shifts stemming from demographic factors. However, it must be stressed that with the growth in the numbers of older persons, especially at extremely old ages, the demands for services of various kinds almost certainly will occur. Much has been said about the effects of reduced fertility and smaller family size on the potential caregivers for the dependent elderly. Examining ratios of younger family members, notably females, to the oldest-old reveals a decline in the ratios to the turn of the century, but they then stabilize at over four females 50-64 for each person 85 years and over.

Far less can be said with any degree of confidence about how the foregoing trends we have discussed will impact on housing demands. The vast majority of older persons tend to "age-in-place" and remain in homes that they own outright. There are, to be sure, so called "geriatric enclaves", especially in central cities, that result largely from out-migration of younger persons. Others develop from selective migration of older persons, often at time of retirement or shortly thereafter. These enclaves demand attention from the standpoint of service demands generated for local communities and, in certain cases, States that have received large-scale immigration of older persons. Another development that merits attention is the increasing numbers and proportions of older persons found in suburban areas, where they often are scattered more diffusely than is typical in central cities. Providing transportion and services for persons in such areas may be demanding at best. The geographic redistribution of the aged will need to be examined more extensively in the future, but current trends display rather crescive growth in the light of only modestly increasing levels of population mobility at older ages.

Specialized housing for selective segments of the aged population -- in retirement communities, condominiums devoted to the elderly, congregate housing, and nursing homes -- have received growing attention from housing developers. To date, these types of housing arrangements, with the possible exception of nursing homes, have relevance for only a small segment of the aged population. With the growth of the older population a market certainly exists, but its impact to date has tended to be minimal. A persistent demand is found for public housing among lower-income older persons, which does merit continuing attention. Moreover, there is a substantial interest in shared housing that has tended to be constrained by existing zoning laws and other housing ordinances. Of perhaps greater importance is the growing proportion of entering cohorts of older persons who already possess or have the resources to obtain second homes.

Thus, we do not envision any major divergencies in the family status, living arrangements, or housing requirements for older persons in the short-term or even through our forecast period.

CONCLUSIONS AND POLICY IMPLICATIONS

We have touched upon a number of demographic changes that deserve close monitoring in the years ahead. This demands oversight and continued research attention. We do not envision any major demographic shifts that cannot be dealt with by responsible action. Outside the purview of our attention are considerations of health care requirements, which would seem to have greater potential for priority attention. The main message I would pass on is not to tinker too greatly with existing policies and programs. The later years of life are filled with degrees of uncertainty in the realms of health, finances and social support. Younger persons need the assurance in planning their remaining years of life that stable structures provide.

Recently, I passed a sign on Interstate 95 in South Carolina that read "Retire As Much As You Want." It referred to an integrated housing community that provides both independent living and other forms of residential maintenance when dependent needs arise. The sign's message could apply to conditions of employment, leisure and social interaction. Older persons want the freedom to choose their way of life, without major constraints placed on this freedom. In the main, federal policy in the past two decades has made this possible -- but this progress should not be eroded.

Three further observations can be made. One, while the vast majority of older persons have positive feelings about their life conditions, there persists a relatively small, but no less important segment, who for one reason or another lack the relative advantages of others. They should remain the targets of continued steps to improve their conditions of life. Without shifting out categorical programs that address the concerns of the elderly as a distinct group, there is further scope for attention to the needs of specific elderly who are poor, infirm, ill-housed or otherwise disadvantaged.

Two, we must guard against the sometimes widely-held stereotypes of old age and the elderly. As our knowledge of the aging process increments, we learn that all abilities do not decline uniformly and that meaningful intervention is possible not only to preserve life, but also meaningful life. Continued federal support of research to future this goal is both the biological and social sciences is required.

Three, there is a "public good" that I have largely ignored in this presentation. There has been a recent spate of attention to issues of inequity in the distribution of federal resources to the old as opposed to the young. This argument is based on three assumptions -- that resources that might be allocated to persons in these age groups are fixed, that empirically the facts about the inequity are correct, and that the old have been responsible through collection action for this development. I take issue with all three assumptions.

The resources are not fixed -- in fact, cross-national comparisons of our levels of support for the elderly per capita, as a share of GNP, are less than in many other industrialized countries. Incidentally, the same is also true for expenditures on the young. Where neglect exists, especially with respect to the young, we should remedy this situation, but not at the expense of the elderly. The second assumption, in fact, may also not be correct. Recent research (Duncan, Hill, and Rodgers, 1986) shows that average family income in relation to needs declined between 1968 and 1982 for cohorts of families with persons aged 60-64 in 1968, while for families with children 0-4 it has increased. However, cross-sectional studies, upon which we often erroneously base our conclusions, show opposite trends for families with young persons and persons 65 and over. This may explain some of the confusion. As to the third point, there is little evidence that suggests that either pressure groups or political blocks of older persons have been mainly responsible for legislation that has improved the conditions of life for older persons. Instead, this legislation has enjoyed widespread bipartisan support, and overwhelming approval by all groups, including young adults, in repeated national polls. Intergenerational conflict may certainly be a future issue, but little evidence exists which suggests it will become a feature of American society.

Duncan, Greg J., Martha Hill and Willard Rogers. 1986. "The Changing Fortunes of Young and Old" American Demographics, 8:8:26-33.

Myers, George C. 1985. "Aging and Worldwide Population Change" in Robert Binstock and Ethel Shanas (eds.) Handbook on Aging and the Social Sciences, New York: Van Nostrand Reinhold, 173-198.

Myers, George C., Kenneth G. Manton and Helena Bacellar. 1986. "Sociodemographic Aspects of Future Unpaid Productive Roles" in Committee on an Aging Society, National Academy of Scieices, Productive Roles in an Older Society, Washington, D.C.: National Academy Press, 110-147.

Rosenwaike, Ira. 1985. The Extreme Aged in America, Westport, Connecticut: Greenwood Press.

Siegel, Jacob S. and Cynthia M. Taeuber. 1986. "Demographic Perspectives on the Long-Lived Society" Daedalus, 115:1:77-117.

U.S. Bureau of the Census. 1984. "Projections of the Population of the United States, by Age, Sex, and Race: 1983-2080," Current Population Reports, Series P-25, No. 952, Washington, D.C.: U.S. Government Printing Office.

FIGURE 1

NUMBERS OF PERSONS AT SELECTED AGES
United States, 1982-2020 (Middle Series Projections)

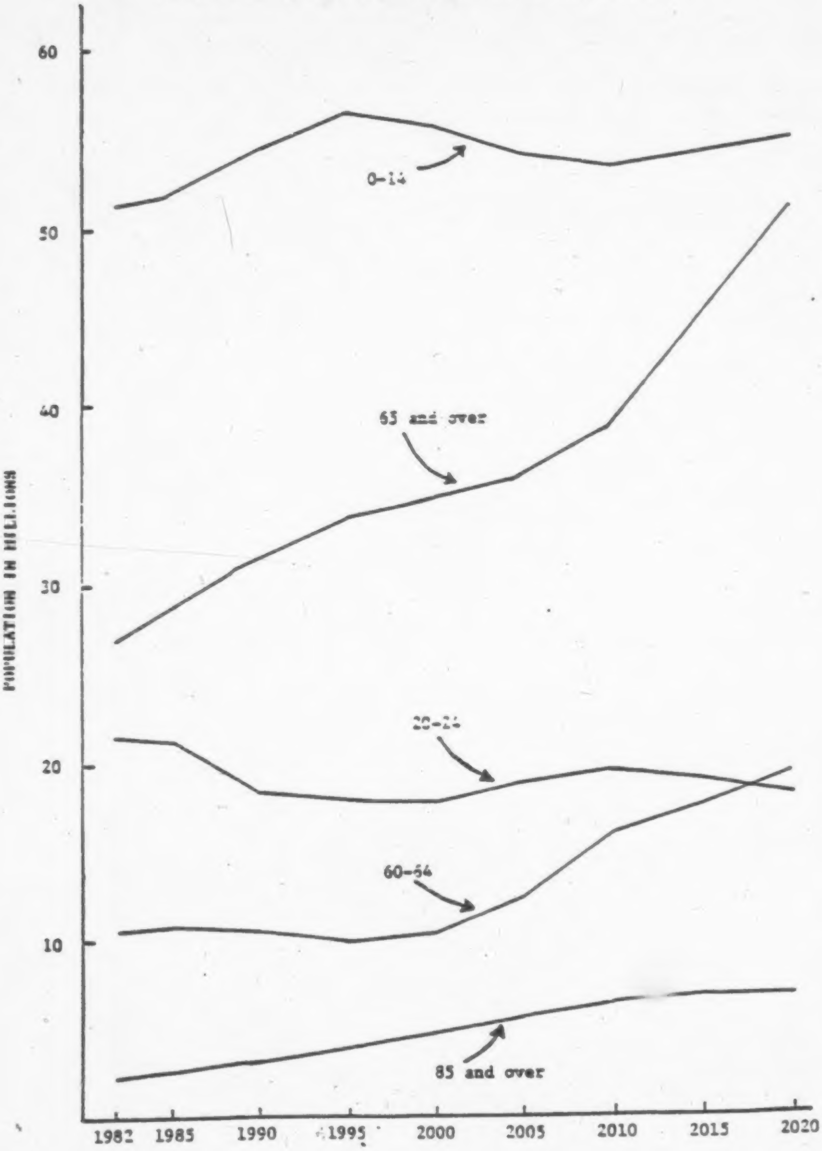

TABLE 1

Selected Statistics on Population 65 Years of Age and Over, United States
1980-2080 (Middle Series Projections)

	YEAR				
	1980	2000	2020	2050	2080
Total Population	25,708	34,921	51,422	67,407	73,289
Percent Aged	11.3	13.0	17.3	21.8	23.5
Ages-Number					
65-69	8,805	9,096	16,520	16,613	16,914
70-74	6,843	8,581	13,235	13,495	14,984
75-79	4,815	7,295	8,824	11,478	12,659
80-84	2,972	5,023	5,662	9,785	10,306
85-89	1,541	3,025	3,587	7,825	7,977
90-94	575	1,355	2,158	4,925	5,433
95-99	130	438	975	2,261	2,946
100+	25	108	361	1,029	1,870
Ages-Percent	100.0	100.0	100.0	100.0	100.0
65-69	34.2	26.0	32.1	24.7	23.1
70-74	26.6	24.6	25.7	20.0	20.5
75-79	18.7	20.9	17.2	17.0	17.3
80-84	11.6	14.4	11.0	14.5	14.1
85-89	6.0	8.7	7.0	11.6	10.9
90-94	2.2	3.9	4.2	7.3	7.4
95-99	0.5	1.2	1.9	3.4	4.0
100+	0.1	0.3	0.7	1.5	2.6
Sex Ratio	67.5	65.0	70.1	68.8	70.0
65-69	80.0	82.1	86.3	90.0	91.0
70-74	72.4	74.6	79.1	83.3	84.9
75-79	62.7	64.8	69.5	74.3	76.5
80-84	53.0	54.5	58.0	63.4	65.9
85-89	45.7	42.3	45.5	51.1	54.1
90-94	39.9	32.8	34.6	40.0	43.6
95-99	35.1	25.9	26.8	32.5	35.1
100+	44.4	20.0	19.9	22.8	24.8
Percent Nonwhite of Total Aged	9.3	10.9	13.8	19.1	23.5
Population Structure Ratios					
20-64/<20	1.79	2.11	2.35	2.36	2.38
20-64/65+	5.04	4.53	3.34	2.52	2.29
20-64/<20+65+	1.32	1.44	1.38	1.22	1.17
65-74/85+	6.38	3.59	4.22	1.88	1.75
65-79/45-49	1.85	1.26	2.20	2.24	2.36

SOURCE: U.S. Bureau of the Census, 1984 "Projections of the Population of the United States by Age, Sex, and Race: 1983 to 2080" Current Population Reports, Series P-25, No. 952; unpublished data used for ages 85-100+ in 1980.

Reproduced from Health promotion and disease prevention for the elderly, by James Reuter, Edward Klebe, and Joseph A. Cislowski. Washington, Congressional Research Service, 1986. p. 9-31. (CRS Report no. 86-40 EPW)

II. DISEASE PREVENTION AND HEALTH PROMOTION FOR THE ELDERLY

Traditionally, preventive health care is subdivided into primary, secondary, and tertiary prevention. Primary prevention is defined as those activities undertaken to prevent the occurrence of disease or illness. Primary prevention involves the identification of risk factors for diseases or disabling conditions (characteristics of individuals indicating an increased likelihood of developing a disease), and reducing or otherwise dealing with them. Secondary prevention includes activities undertaken after a disease can be detected but before it is symptomatic. Secondary prevention includes early detection and treatment of diseases. Tertiary prevention activities are those measures undertaken to prevent the progression of symptomatic diseases, including rehabilitation after treatment to prevent long term disability.

The traditional distinctions between primary, secondary, and tertiary prevention tend to blur when considering prevention activities for the elderly. A single activity may simultaneously be secondary prevention for one condition and primary prevention for another. For example, the detection and treatment of hypertension is secondary prevention for hypertensive disease, whereas control of hypertension (tertiary prevention) is primary prevention for heart disease and strokes. 1/

1/ The organization and much of the content of this section is taken from a recent review of the disease prevention and health promotion literature by: Kane, R. L., R. A. Kane, and S. B. Arnold. Prevention and the Elderly: Risk-Factors. Health Services Research, v. 19, no. 6, Part II, Feb. 1985. p. 946-1006.

A. Diseases Amenable to Traditional Prevention Measures

Traditional disease prevention strategies, e.g., risk-factor reduction (primary prevention), early detection and treatment (secondary prevention), and rehabilitation (tertiary prevention), can be used to reduce the mortality and morbidity of the elderly due to many common diseases. Primary prevention activities might include vaccination programs aganinst influenza and pneumonia, and dietary counseling to reduce the intake of salt and saturated fats (risk-factors for heart disease and strokes) and to increase the intake of vitamin D and calcium in elderly woman (risk-factors for osteoporosis). Early detection and treatment could be used to reduce the mortality and morbidity related to certain cancers, such as breast and colorectal cancer. Rehabilitation can be used to assist patients recovering from acute conditions, such as heart attacks or hip fractures, to return to near normal levels of functioning and, perhaps, avoid recurrences or the need for long-term institutionalization.

This section summarizes the risk-factors associated with five of the leading causes of mortality and morbidity for the elderly: heart disease, stroke, cancer, accidents (osteoporosis), and infectious diseases (influenza and pnuemonia). The potential role for prevention activities related to these conditions are also described.

1. Heart Disease

Heart disease is the leading cause of death of the elderly, accounting for more than half of all deaths in persons age 70 and above. 2/ The risk of cardiovascular disease increases with age. While males have a higher risk of heart

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2/ Kane, Prevention and the Elderly, p. 949.

disease than females, this difference tends to disappear among the elderly. Biological risk factors related to heart disease have been well documented by long-term studies. 3/ These risk factors include such underlying conditions as hypertension (elevated blood pressure), hypercholesterolemia (high cholesterol levels in the blood), and diabetes. Behavioral risk factors for heart disease include smoking, a sedentary life-style, poor dietary habits (obesity and diets high in saturated fats), and stress. Some of the behavioral risk factors are related to the biological risk factors. For example, smoking, a stressful life-style, and lack of exercise are all related to high blood pressure, itself a biological risk factor for heart disease.

Prevention of heart disease involves the reduction of individuals' risk factors, including: smoking cessation; modifications in diet both to reduce blood pressure (reduction of salt intake) and blood cholesterol levels (reductions in intake of saturated fats); changes in life style (exercise and stress reduction programs); and treatment and control of hypertension. 4/ There is some evidence that on a national basis, efforts to reduce these risk factors have been somewhat successful and have resulted in reductions in mortality due to heart disease over the past 20 years. 5/

2. Stroke

Cerebrovascular disease (stroke) has many of the same risk factors as heart disease. The biological risk factors associated with strokes are: high blood

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3/ Kannel, W. B., and T. Gordon. Cardiovascular Risk Factors in the Aged: the Framingham Study. In Haynes, S. G., and M. Feinlieb, eds., Second Conference in the Epidemiology of Aging. DHEW Pub. No. (NIH) 80-969, Bethesda, Md., 1980.

4/ Kane, Prevention and the Elderly, p. 954-959.

5/ U.S. Department of Health and Human Services. Public Health Service. Health and Prevention Profile, 1983. p. 19-31.

pressure, high levels of serum cholesterol, and diabetes. Behavioral risk factors include: smoking, lack of exercise, and poor diet (high in salts and saturated fats). 6/ There is some evidence that strokes may be due in part to irreversible damage occurring over a long period of time. For example, persons with a history of control over their diabetes have lower risk for stroke than persons who have not been able to control their diabetes over an extended period of time. 7/ Strokes are the third leading cause of death of the elderly. 8/

Prevention of strokes is similar to prevention of heart disease, including smoking cessation, dietary modification, and blood pressure control. In addition, there is some evidence that certain medications (anticoagulants, aspirin, and vasodilators) are beneficial in preventing subsequent strokes. 9/

Functional disabilities following an acute stroke are a problem for stroke patients. Rehabilitation to recover functional skills has become an accepted part of medical treatment for many stroke patients. However, while evaluations of rehabilitation programs show some recovery of so-called "activity of daily living" skills (e.g., bathing, eating and dressing), it is not clear whether rehabilitation reduces patients' need for institutionalization. 10/

6/ Kane, Prevention and the Elderly, p. 959.

7/ Ibid., p. 960.

8/ U.S. Department of Health and Human Services. Public Health Service. Health and Prevention Profile, 1983. p. 187.

9/ Ibid., p. 960.

10/ Ibid., p. 961.

3. Cancer

Cancer is the second leading cause of death among the elderly. The most common cancers among the elderly are lung, breast (women), prostate (men), colorectal, and pancreas. 11/ Risk factors for cancer include smoking (lung cancer), diets low in fiber (colorectal cancer), excessive exposure to sunshine (skin cancer), and exposure to environmental hazards such as air pollution. While there is no known method of preventing many cancers, early detection and treatment can sometimes eradicate the disease in a patient, or at least prolong the patient's life. Thus, unlike some stroke and heart disease prevention programs that are focused on primary prevention activities (risk-reduction), cancer prevention also includes an emphasis on secondary prevention (early detection and treatment).

Breast cancer can be detected in its early stages, and early detection improves the patient's prognosis. The 5-year survival rates for elderly women with "localized" breast cancer treated by radical mastectomy is 85 percent. The five-year survival of elderly women with "regional" breast cancer is only 53 percent. 12/ A recent study suggests that for women who seek medical care for breast cancer while the disease is in its early stages, localized excision of the cancer may be a viable option to the traditional radical mastectomy. 13/ This finding may encourage women to seek early treatment to avoid the need for a radical mastectomy.

11/ Ibid., p. 963.

12/ Ibid., p. 965.

13/ Fisher, B., et al. Five-year results of a randomized clinical trial comparing total mastectomy and segmental mastectomy with or without radiation in the treatment of breast cancer. The New England Journal of Medicine, v. 312, no. 11, Mar. 14, 1985. p. 665-673.

Breast cancer can be detected in a variety of ways, including physical examination, thermography, and mammography. Also, women practicing breast self-examination have been able to detect breast cancer in its early stages. The American Cancer Society (ACS) recommends that all women over age 20 practice breast self-examination and that women over age 50 have a breast physical examination and a mammography for breast tumors every year. 14/

Cancer of the cervix can be detected using the Papanicolaou (Pap) cytologic smear test. This test has been in wide use since the 1950s. However, data from health surveys suggests that many women discontinue regular pap smears after menopause. 15/ The ACS recommends that, after two successive negative smears, women should have a pap smear every three years until reaching age 65. The upper age limit in this recommendation is due to a low number of cases detected in women in this age group who have previously been screened. 16/ However, it should be noted that only 59 percent of women over age 65 have ever had a pap smear. 17/

Colorectal cancer has the highest incidence of cancer mortality for persons over age 75 (men and women combined). A simple laboratory test known as the guaiac test for fecal occult blood (a test for blood in the stool) is one method for screening for colorectal cancer in its early, localized stage. A digital rectal exam and a sigmoidoscopy examination can also be used to detect colon cancer. For persons over age 50, the ACS recommends an annual digital exam and

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14/ American Cancer Society. Guidelines for the Cancer-Related Checkup: Recommendations and Rationale. American Cancer Society, Inc., New York, New York, 1980. p. 41.

15/ Kane, Prevention and the Elderly, p. 966.

16/ American Cancer Society. Guidelines for Cancer-Related Checkup. p. 41.

17/ Kane, Prevention and the Elderly, p. 966.

and guaiac test, and a sigmoidoscopic exam every three to five years. However, the ACS also notes that the value of these tests for mass screening programs have yet to be proven in controlled studies. 18/

It should be noted that despite the indications of the value of early detection for some cancers, many of the elderly are not regularly screened. One study showed that only 27 percent of persons over age 70 accepted an invitation to take the guaiac screening test for colorectal cancer. 19/ There are a wide variety of hypotheses regarding why so few avail themselves of opportunities for cancer screening, including fear of a positive result (especially in regard to breast cancers), lack of knowledge regarding treatment alternatives, false beliefs, and unpleasantness of the procedures (e.g., sigmoidoscopy).

4. Accidents

Accidents, primarily motor vehicle accidents and falls, are the eighth leading cause of death of the elderly. Deaths from motor vehicle accidents account for 24 percent of all accidental deaths of the elderly. 20/ Only 10 percent of the elderly regularly use their seat belts while driving. An increase in seat belt usage might reduce the number of elderly dying in automobile accidents. Several States have recently implemented laws mandating seat belt usage by drivers and front seat passengers.

Falls, frequently resulting in fractures, are also a significant problem for the elderly. The risk of fractures increases with age, especially among

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18/ American Cancer Society. Guidelines for Cancer-Related Checkup, p. 41.

19/ Kane, Prevention and the Elderly, p. 967.

20/ National Center for Health Statistics. Advance Report, Final Mortality Statistics, 1982. p. 21-23.

women. The incidence of hip fractures in women between ages 75 and 79 is six per 1000 women, increasing to 48.6 per 1000 for women over age 90. 21/ Depending upon the population studied, the one-year mortality following hip fractures ranges from 12 to 67 percent. Forty-one percent of hip fracture cases are discharged from the hospital into a nursing home. The potential benefits of reducing the incidence of falls and fractures includes not only reduction in the mortality and disability resulting from these accidents, but also reductions in the cost of treating these injuries and in the cost of institutionalizations for those persons who require nursing home care.

Some falls are caused by environmental factors, such as frayed rugs, electrical cords, and icy sidewalks. Some are due to conditions such as Parkinson's disease, seizures, alcoholism, and strokes. It has been suggested that appropriate diagnosis and treatment of these conditions, as well as correction of vision impairments, could reduce the incidence of falls among the elderly. 22/

Osteoporosis (low bone mass) increases the risk of fractures due to falls. Osteoporosis is associated with increased bone resorption and decreased bone formation primarily among post-menopausal women. While the causes of osteoporosis are not well understood, it appears to be associated with the post-menopausal decline in estrogen levels. While estrogen replacement therapy (ERT) has been shown to arrest the loss of bone mass, ERT increases the risk of endometrial cancer (cancer of the uterine lining). Other risk factors associated with osteoporosis include: a history of diabetes, a history of use of steroids, poor nutrition (a diet low in calcium), and lack of exercise. Primary prevention of

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21/ Ibid., p. 967.

22/ Kane, Prevention in the Elderly, p. 968.

this condition begins at menopause and includes increased exercise, vitamin D supplementation, and increased calcium intake. 23/

Post-fracture rehabilitation, including early weightbearing, has been shown to be an important factor in the recovery from hip fractures. However, even patients participating in intensive rehabilitation programs and living at home generally require some home care services.

5. Infectious Diseases

Most infectious disease prevention programs are focused on childhood diseases (such as smallpox and diphtheria) with two notable exceptions: influenza and pneumonia. These conditions are the fourth leading cause of death of the elderly, accounting for a mortality rate of 170 per 100,000 elderly persons. Nationally, pneumonia accounts for more than 50,000 deaths per year, more than half of which occur in people over 65 years of age. The elderly are more susceptible to infections, due in part to a decreased immune response and to the presence of other medical conditions. Institutionalized persons are also at greater risk of exposure to infectious diseases; the annual incidence of institutionally acquired pneumonia is around 100 per 1,000 elderly patients, as opposed to only 25-44 per 1,000 elderly in the community. 24/

Because pneumonia is frequently a result of influenza, some have argued that prevention efforts should be directed toward preventing influenza through the use of influenza vaccinations. The Public Health Service has an explicit goal of achieving 60 percent vaccination against influenza among high-risk populations (including the elderly) by the the year 1990. Only about 20 percent of

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23/ Ibid., pp. 969-970.

24/ Kane, Prevention and the Elderly, p. 972-973.

the elderly now receive this vaccination. 25/ Some data suggest that pneumococcal pneumonia vaccinations may be more cost effective for the elderly. This is due in part to the fact that influenza vaccinations must be given annually whereas the pneumococcal vaccination retains its effectiveness over several years. However, questions have been raised regarding the effectiveness of both types of vaccines, due in part to a poorer antibody response to vaccinations in the elderly as compared to younger populations. 26/

B. Health Promotion and Education

As indicated in the discussion above, susceptibility to many conditions is a function of certain risk-factors related to a person's life-style and personal habits. Although direct evidence linking the modification of some habits with improved health is lacking (with the notable exception of smoking cessation), most agree that encouraging a healthy life-style is worthwhile.

Health promotion and education programs may have a variety of objectives and be pursued in many different settings. These programs' objectives might include information dissemination, education on risk-factors, behavior modification (such as in smoking cessation classes), counseling, and social support and encouragement of behavioral change. These programs and activities can be incorporated into regular visits with medical personnel, provided through special classes and seminars (such as exercise, smoking cessation, weight loss or stress

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25/ U.S. Department of Health and Human Services. Public Health Service. Promoting Health/Preventing Disease: Public Health Service Implementation Plans for Attaining the Objectives for the Nation. Public Health Reports. Supplement, September-October 1983. p. 47.

26/ Kane, Prevention and the Elderly, p. 973.

management courses), or simply provide information to the general public through the media (television and newspapers) or by direct mailings.

These interventions do not fit easily into the traditional models of medical treatment and health insurance. Also, it has been suggested that some of these "interventions" can be vehicles for the economic exploitation of elderly persons concerned about their health and well-being, such as in the marketing of food supplements.

1. Smoking

Smoking is associated with a wide range of health conditions. In addition to the specific conditions discussed above (heart disease, strokes, hypertension, and lung cancer), smoking is also related to chronic bronchitis and emphysema. While the benefits of smoking cessation are most easily documented in non-elderly populations, there is substantial benefit to be achieved at all ages. While the incidence of lung cancer does not decline until several years after stopping smoking, the risk of heart disease, chronic bronchitis, and emphysema declines relatively rapidly. 27/

2. Diet

A healthy diet for the elderly differs in several respects from a healthy diet for younger populations. This is due in part to the increased risk for certain diseases among elderly populations and to physiological changes occurring as part of the aging process.

27/ Ibid., p. 973-974.

The risk factors related to heart disease and stroke suggest that elderly persons should reduce their intake of saturated fats (i.e., sources of cholesterol) and salt. However, some older persons who consume packaged foods or take their meals at congregate meal sites, such as in the dining rooms of nursing homes or retirement villages, may have difficulty limiting their intake of these substances. 28/

The risk of osteoporosis among elderly women suggests that they may not get sufficient levels of calcium and vitamin D in their diets. However, with the exception of supplementation of these two substances, there is little evidence to suggest the value of either widespread use of general purpose vitamins or the use of large doses of vitamin supplements. 29/

3. Exercise

Exercise in moderation is generally believed to be good. In addition to the physical benefits, a program of regular activity can also enhance an older person's mental outlook through promotion of a general sense of well-being. Persons with a sedentary life-style are at higher risk for heart disease, hypertension, strokes and osteoporosis. Data suggest that habitual vigorous physical activity does reduce the risk of coronary heart disease. 30/

28/ Ibid., p. 974.

29/ Ibid.

30/ Siscovick, D. S., R. E. Laporte, and J. M. Newman. The Disease-Specific Benefits and Risks of Physical Activity and Exercise. Public Health Reports, v. 100, no. 2, Mar.-Apr. 1985. p. 180-188.

C. Chronic Impairments and Functional Disabilities

As they age, the elderly are more likely to suffer from chronic impairments. While these impairments are not life-threatening, they can affect the functional capabilities of the elderly. Also, while many of these impairments are amenable to intervention, it has been suggested that they frequently are ignored or given insufficient attention in the course of regular medical care. 31/

1. Vision and Hearing

Vision and hearing problems are common among the elderly. Nearly 60 percent of persons age 65 to 74 have either cataracts or glaucoma. In 1977, 16 percent of elderly persons reported that, at best, they could hear only shouted speech. While these problems are common, data suggest that the elderly were less likely than younger persons to have vision and hearing tests during their regular medical checkups. 32/ Uncorrected vision and hearing problems may increase the risk of accidental falls and, particularly in the presence of osteoporosis, fractures.

2. Mental Health Needs of the Elderly

Even though there is a higher incidence of mental illness in the elderly than in younger populations, little research has been done on the mental health needs of the elderly. For many years, elderly persons with mental disorders were simply diagnosed as senile. While senility is often due to organic deterioration, evidence suggests that this diagnosis also may mask a number of diverse

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31/ Kane, Prevention and the Elderly, p. 976.

32/ Ibid.

conditions. In some cases, these underlying conditions, such as depression, anxiety, and psychosomatic disorders, may be responsive to medical and psychotherapeutic interventions. 33/

Depression among the elderly is a common but complex problem. The symptoms of depression may be associated with other physical impairments, and thus can be difficult to identify. Also, it is difficult in elderly populations to distinguish between depression due to normal grieving processes or stress related to loss of loved ones or to changes in functioning and life-style from conditions which may respond to counseling, chemotherapy, or social interventions. 34/ It has been suggested that people who are at high risk for depression could be identified and encouraged to participate in preventive counseling or therapy. These persons might include those who recently retired, whose spouse recently died, or who have recently been admitted to a nursing home.

The management of depression in the elderly has an important role in an overall program of disease prevention and health promotion. Stress and emotional factors can precipitate a physical illness or delay recovery. Also, if not carefully managed, the medications used to treat depression and other mental illnesses can produce serious side effects (dizziness, visual disturbances, and sedation). Some of these medications have been implicated as causes of unnecessary falls and injuries among the elderly. 35/

It has been suggested that the treatment of emotional problems can reduce the utilization of medical care services. Reductions in the cost of medical

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33/ U.S. Library of Congress. Congressional Research Service. The Elderly and the Health Care Dilemma: Is an Ounce of Prevention Worth a Pound of Cure? Typed Report, by J. Mielke, Mar. 20, 1985. Washington, 1985. p. 7-9.

34/ Kane, Prevention and the Elderly. p. 980-982.

35/ Ibid., p. 986.

care services due to the provision of mental health services is sometimes referred to as the "offset" effect. That is, savings due to decreases in medical utilization offset the costs of mental health services. A survey of studies of the offset effect showed that in 12 of 13 studies, persons receiving mental health services used fewer physician services and had lower hospital utilization rates after initiating mental health treatment. However, the reductions in medical care utilization did not fully offset the costs of the mental health services. In one study which computed the net cost of the mental health interventions in four different settings, the savings from reduced medical care offset between four and 67 percent of the costs of the mental health care. Thus, the offset effect may not generate a net savings, but only reduce the net cost of mental health services. 36/

3. Alcohol Abuse and Alcoholism

Surveys on alcohol use generally show an overall decline in use with age. However, among those elderly persons who do drink, many have alcohol-related problems. Estimates of the number of elderly alcoholics range from 7 to 30 percent of the population over age 60. 37/ Some experts suggest that even the higher figures may underestimate the extent of this problem. Problem drinking among the elderly is often hidden, taking place within the confines of the home. Friends, relatives, and those providing care may fail to correctly identify the problem, mistaking its symptoms as frailty, senility, or the unsteadiness of old age.

36/ Jones, K. R., and T. R. Vischik. Impact of Alcohol, Drug Abuse and Mental Health Treatment of Medical Care Utilizaiton. A Review of the Research Literature. Medical Care, v. 17, no. 12, Supplement, Dec. 1979. p. 1-26.

37/ Kane, Prevention and the Elderly, p. 982.

Although alcohol abuse is serious at any age, there are factors which exacerbate the seriousness of the problem for the elderly. For example, when mixed with some medications, alcohol can produce serious side-effects. Alcohol abuse can also increase the incidence of accidents and injuries.

Problem drinkers in old age are generally one of two types. The first are chronic or early-onset alcohol abusers who have abused alcohol throughout their lives. The second type are late-onset drinkers. This pattern of drinking may be a response to situational factors such as retirement, declining income, or the loss of a spouse or friend. Alcohol may first be used for temporary relief and then evolve into a pattern of problem drinking. It has been suggested that it may be possible to prevent some late-onset alcoholism by providing counseling and support to elderly persons to help them deal constructively with problems which may lead to alcohol abuse. 38/

There are a variety of treatments, programs, and modalities which can be used to help the elderly alcohol abuser including detoxification, drug therapy, behavior modification, self-help groups such as Alcoholics Anonymous, and counseling. However, it has been suggested that many of the existing resources for the treatment of alcohol problems are oriented toward persons in the workforce with the goal of a return to employment. This goal may be inappropriate for older problem drinkers.

As with mental health treatment, it has been suggested that the cost of alcoholism treatment is offset through reductions in medical care utilization. A survey of 12 studies found a median value of 40 percent of the cost of alcoholism treatment was offset by reduced medical care utilization. 39/

38/ Ibid., p. 983.

39/ Jones and Vischi, Impact of Alcohol, Drug Abuse, and Mental Health Treatment on Medical Care Utilization, p. 1-26.

D. Iatrogenic Illness

Interventions related to iatrogenic illnesses are the fourth and final major category of activities of health promotion and disease prevention for the elderly. Iatrogenic illnesses are defined as illnesses or conditions arising from the provision of medical care. The most common iatrogenic illnesses among the elderly are drug reactions (side effects of overmedication and drug-to-drug interaction effects) and nosocomial infections (infections occuring during episodes of institutionalization).

1. Drug Reactions

Elderly persons constitute only 11 percent of the population but consume 25 percent of the drugs in the United States. 40/ Estimates of the average number of prescription drugs being used by elderly persons range from 1.6 to 2.3 prescriptions per person. In one study of elderly persons living independently, 18 percent used between five and nine different prescription medications concurrently. 41/ This high rate of multiple prescriptions increases the probability of adverse drug-to-drug interactions. Data show that the elderly experience medication side effects at a rate 1.5 to 3 times higher than that of younger persons.

The elderly frequently have multiple disorders, and may seek care from several physicians simultaneously. Elderly patients may not inform each doctor of what other doctors have prescribed. Also, doctors may overlook aspects of a

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40/ Ibid., p. 985.

41/ Ostrom, J. R., E. R. Hammarlund, D. B. Christensen, J. B. Plein, and A. J. Kethley. Medication Usage in an Elderly Population. Medical Care, v. 23, no. 2, Feb. 1985. p. 157-164.

patient's history. These circumstances can lead to instances of gross over-medication and serious drug interactions. 42/

The aging process includes physiological changes which alter the effects of medication, increasing the difficulty of determining the correct dosage for an older person. Additionally, most preliminary trials of medications are done on young subjects and provide few guidelines for adjusting dosages for older patients. 43/

Several strategies have been suggested for reducing the incidence of iatrogenic illnesses due to medications. These include: case management plans wherein elderly patients are encouraged to coordinate their medications through a primary care physician or family pharmacist, patient education provided at the time the medication is prescribed, and careful monitoring of drug therapy to ensure that dosages are kept to the minimum level necessary to produce the desired therapeutic effect. 44/

2. Nosocomial Infections

Nosocomial infections are defined as infections that develop during a period of institutionalization, either in a hospital or nursing home. The risk for nosocomial infections is three times higher in the elderly than in the general population, due in part to the higher rates of institutionalization for the elderly and to the lowered resistance of the elderly to such infections. Urinary

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42/ U.S. Library of Congress. Congressional Research Service. The Elderly and the Health Care Dilemma: Is an Ounce of Prevention Worth a Pound of Cure? Typed Report, by J. Mielke, Mar. 20, 1985. Washington, 1985. p. 9-12.

43/ Kane, Prevention in the Elderly, p. 986.

44/ Ibid., p. 988.

tract infections (UTIs) are a common problem for the elderly. Between 30 and 50 percent of institutionalized elderly persons have UTIs. Individuals with indwelling urinary catheters have a high risk of acquiring a UTI, and preventive stategies have tended to focus on this group. There are some data that suggest that the use of certain types of urinary catheters can reduce the incidence of UTIs. 45/

E. The Benefits of Preventive Measures for Elderly Populations

In general, the development of cost-benefit data for any prevention program is difficult, usually requiring data to be collected on large samples of people over many years. In addition, while the costs of prevention programs can be measured or estimated, measurement of the benefits is frequently value-laden, depending upon subjective determination of the worth of many benefits such as preventing the deterioration of a functional impairment or increasing a person's life expectancy.

The problem of estimating the value of the benefits of prevention for the elderly is more difficult than for younger populations. The potential benefits for the elderly are improvements in quality of life, decreased disability levels, increased life-expectancy, and reduced medical care expenditures. Excluded from this list are some of the economic benefits that are relevant for employed populations (such as decreased absenteeism or increased productivity) but that are inappropriate for many of the elderly.

While changes in quality of life and levels of disability can be measured, at least on a conceptual basis, it is difficult to place a specific dollar value on these benefits. In addition, there are disagreements as to the potential

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45/ Kane, Prevention and the Elderly, p. 988-989.

impact of preventive care for the elderly in regard to changes in life-expectancy and the cost of medical care. It has been argued that there exists a theoretical upper limit to a natural life span, estimated to be around 85 years of age. 46/ Also, there are data suggesting that a large proportion of Medicare expenditures are related to care provided during the last two years of a person's life. 47/ If there is an upper limit to natural life expectancy, then a potential goal of preventive care for the elderly would be to shorten the period of morbidity preceding death by increasing the age of onset of chronic or terminal illness. The decrease in the period of morbidity preceding death would thus reduce health care expenditures. However, others have argued against the concept of an upper limit to life expectancy. In the absence of an upper limit, preventive care may increase life expectancy without decreasing medical care expenditures as the period of morbidity and high use of medical care preceeding death would not necessarily be decreased. In this case, one outcome of increased life expectancy might be to increase medical care expenditures by lengthening the period of morbidity.

Given the problems of measuring the benefits of prevention programs for the elderly and the conceptual disagreements as to the potential outcomes of prevention on life expectancy and the cost of medical care, it is not surprising that little is known about the value of prevention for the elderly. Much of what is known about the risk factors for disease and the value of interventions is drawn from studies of younger populations wherein the benefits are easier to measure

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46/ Fries, J. F. Aging, Natural Death, and the Compression of Morbidity. The New England Journal of Medicine, v. 303, no. 3, July 17, 1980. p. 130-135.

47/ Lubitz, J. and R. Prihoda. Use and Cost of Medicare Services in the Last Two Years of Life. Health Care Financing Review, v. 5, no. 3, spring 1984. p. 117-132.

and demonstrate. Little is known about the relevance of the evidence from studies of younger populations to older persons.

There have been some studies that have examined the effects of efforts to reduce risk factors for disease among elderly populations and that have suggested some positive benefits. A longitudinal study in Alameda County, California suggests that elderly persons who had healthier life-styles (e.g., no cigarette smoking, moderate exercise, moderate alcohol use) were less likely to die during the study's nine and one-half year follow-up period. 48/ There is also some evidence that the treatment of even mild cases of hypertension can reduce mortality. 49/ Finally, there is some evidence from community-based studies suggesting that community-wide health promotion efforts can reduce the prevalence of risk factors and reduce mortality for certain diseases.

While there is some evidence supporting the value of health promotion and disease prevention for the elderly, many questions remain regarding the economic benefits of these efforts. A recent conference sponsored by the Foundation for Health Services Research generated a proposed research agenda which focused on the deficiencies in our current knowledge. This agenda included research on the appropriate design of health education programs for the elderly and on the relationship between health care services and the functional status of elderly persons. 50/ However, until additional research is completed, determining the

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48/ Breslow, L. and J. E. Enstrom. Persistence of Health Habits and Their Relationship to Mortality. Preventive Medicine, v. 9, 1980. p. 469-483.

49/ Hypertension Detection and Follow-up Program Cooperative Group. The Effect of Treatment on Mortality in "Mild" Hypertension. The New England Journal of Medicine, v. 307, Oct. 14, 1982. p. 976-980.

50/ Defrise, G. H., A. S. Hersh, and M. A. McManus. A Proposed Research Agenda for Health Promotion and Disease Prevention for Children and the Elderly. Health Services Research, v. 19, no. 6, Part II, Feb. 1985. p. 1033-1042.

economic and social value of preventive interventions for the elderly may remain an elusive goal.

F. Summary

There is a wide range of potential strategies of health promotion and disease prevention for the elderly. Prevention activities that fall within the traditional scope of preventive medical care include control of hypertension (reduction of the risk of heart disease and stroke) screening for breast and colorectal cancers and wider use of influenza and pneumococcal pneumonia vaccines. Health education efforts (by physicians and others) could focus on smoking behavior, the value of smoking cessation at any age (reduction in the risk of heart disease, stroke, lung cancer, emphysema, and chronic bronchitis), dietary counseling to reduce cholesterol and salt intake (risk factors of hypertension, heart disease, and strokes) and to increase calcium and vitamin D intake in women (reduction in the risk of osteoporosis), and counseling in regard to the value of regular exercise (reduction in the risk of heart disease, stroke, and osteoporosis). Finally, some observers note that the medical profession could do more during the course of routine medical care to improve the functioning of elderly persons (diagnosis and treatment of depression, and vision and hearing disabilities) and to reduce the incidence of iatrogenic illness, particularly those related to drug reactions.

However, while there are many opportunities for health promotion and disease prevention activities, and many humanitarian reasons for pursuing them, the economics of these efforts in the elderly remains unclear. There are few studies that demonstrate actual direct dollar savings (reductions in health care expenditures) or indirect savings, such as through increases in productivity, decreases in disability days or increases in "well-being." Also, most research on health promotion and disease prevention has been based on studies of younger populations and we know little about whether the results of these studies transfer to older populations.

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TESTIMONY FOR THE FINANCE SUBCOMMITTEE

UNITED STATES SENATE

from the

American College of Preventive Medicine

PREVENTIVE HEALTH CARE SERVICES FOR THE ELDERLY

Although 11% of the United States population is over the age of 65, the elderly consume 30% of the nation's health care dollars and 50% of the federal health budget (1). These figures reflect the elaborate medical attention required by the elderly and the considerable expense of long-term institutionalization of 1.5 million individuals (2). Services on this scale are necessary to treat the serious diseases which are especially common among the elderly. These include heart disease; cancer of the lung, breast, colon, cervix, and prostate; cerebrovascular disease; diabetes; pulmonary disease; dementia and depression; injuries and disability; and many others (3).

We now know that most of these medical conditions can be prevented. They are caused by behavioral and environmental risk factors that can be eliminated earlier in life. Indeed, it has been estimated that at least 60% of all health problems are the result of such influences (4). One risk factor, the use of tobacco, is by itself responsible for about 320,000 deaths annually, and is the attributable cause of 30% of all cancers, 85% of lung cancers, and up to 30% of coronary heart disease (5-7). Nutritional links to heart disease, cancer, and many other conditions are well established (3).

Experience has taught us that preventive strategies directed at reducing exposure to these risk factors can be dramatically successful in lowering the prevalence of chronic diseases and improving the life expectancy of the average American. The reduction in the incidence of coronary artery disease over recent years is not due to technological advances in surgical methods and intensive care medicine but is primarily the result of changes in the exercise and nutritional habits of Americans (8). The control of hypertension has also been instrumental in this trend and the 32% decline in the occurrence of strokes (3). Tests for the early detection of cancer have dramatically improved five-year survival for cancer of the colon, breast, and cervix, which together account for over 110,000 deaths each year (9). Mortality from cervical cancer has decreased steadily with the implementation of Pap smear screening programs (10,11). Evidence supporting the value of counseling regarding nutrition, smoking, and other risk factors has been strengthened by large multicenter trials such as the Lipid Research Clinics (LRC) Coronary Primary Prevention Trial (12) and the Multiple Risk Factor Intervention Trial (MRFIT) (13).

Since preventive strategies are more effective if initiated early in life, there is a common misconception that prevention is of little value to the elderly. In actuality, the elderly have much to gain. The average 65-year-old can expect to live an additional 15 years and the average 75-year-old can expect to live another ten (1). This is a "window" of opportunity, during which the occurrence and severity of a variety of serious and disabling conditions can be reduced effectively through established preventive maneuvers.

Unfortunately, these preventive maneuvers are not offered to all older Americans. Warning signs are left undetected and risk factors untreated until the symptoms of the disease bring the individual to medical attention. By this time many diseases are very advanced and the potential for meaningful clinical intervention is quite limited. This delay in care is a personal tragedy for the elderly individual and, on a societal level, has serious implications for the health care system that must provide for them. Medical treatment at these late stages often requires dramatic and costly procedures that involve expensive technology. Despite the sophistication of modern therapeutic modalities, delayed treatment is often unable to return to the elderly patient the functional status needed to live outside of an institutionalized setting. Thus nursing home and hospital care becomes necessary. This is expensive, is associated with a poorer quality of life, and increases the patient's risk for further medical problems.

This form of caring for older Americans is difficult to justify in an era when these diseases can be prevented in their early stages (secondary prevention) or before they occur (primary prevention). There are three types of preventive strategies: (1) screening and early detection tests; (2) counseling and patient education; and (3) immunizations and chemoprophylaxis.

Screening tests identify persons at risk for a disease before it occurs. Examples include the Papanicolaou smear and the measurement of serum cholesterol in order to prevent cervical cancer and coronary artery disease, respectively. Early detection maneuvers permit more successful treatment in the initial stages of a disease, as in the detection of cancer through mammography and fecal occult blood testing. Patients respond to physician counseling by changing unhealthy practices and behaviors such as the use of tobacco and drugs; diets high in fat and salt but low in fiber; lack of exercise; and riding in an automobile without occupant restraints. A variety of conditions, primarily infectious diseases, can be prevented through immunizations and chemoprophylaxis (e.g. vaccines, drugs that lower serum cholesterol, and estrogen to prevent osteoporosis).

Preventive interventions are available to the elderly in each category, and many of these are listed in the following table. It should be emphasized at the outset, however, that (1) preventive services differ from diagnostic tests in that they are offered to healthy asymptomatic persons to prevent disease, rather than to obtain a diagnosis after the person has become ill; (2) since these interventions must be tailored to each individual's age, sex, and risk profile, not all items in this list are appropriate for all elderly persons; (3) the strength of the scientific evidence for each procedure is variable; and (4) preventive services are not the domain of only one specialty but in fact are performed by all primary care specialties (e.g. internal medicine, family practice, gynecology).

SCREENING AND EARLY DETECTION TESTS

- Measurement of serum cholesterol, a leading risk factor for coronary heart disease.

- Measurement of blood pressure, a risk factor for coronary heart disease, stroke, and kidney disease.

- Mammography screening to detect breast cancer.

- Fecal occult blood tests of the stool and sigmoidoscopy to detect cancer of the colon and rectum.

- Papanicolaou smear to detect cervical cancer.
- Digital rectal examination to detect prostate cancer.
- Measurement of height, weight, and skin-fold thickness to detect obesity, a risk factor for heart disease, diabetes, and hypertension.
- Visual acuity and auditory testing to screen for sensory deficits.
- Mental health screening to detect dementia and depression.
- Screening for alcohol and drug abuse.
- Screening for inadequate social support systems, home care, and functional status.
- Screening for podiatric disorders and incontinence.

COUNSELING AND PATIENT EDUCATION

- Self-examination instructions to detect breast and skin cancer.
- Smoking cessation counseling to prevent cancers of the lung, larynx, pharynx, oral cavity, esophagus, pancreas, kidney, and bladder; coronary artery, cerebrovascular, and peripheral vascular diseases; chronic obstructive pulmonary disease; peptic ulcer disease; and respiratory infections. (Involuntary, or passive, smoking may increase the risk of lung cancer in healthy nonsmokers and the frequency of respiratory illness among children.) (5-7)
- Exercise instructions to enhance fitness, functional mobility, and to prevent coronary heart disease and osteoporosis.
- Nutritional counseling regarding caloric balance, dietary fat, sodium, fiber, and carbohydrates to prevent heart disease, cancer, obesity, hypertension, and diabetes.
- Safety instructions to prevent injuries and death from motor vehicle crashes, household accidents, falls, and low back injury.
- Dental hygiene instructions to prevent caries, periodontal disease, and malocclusion.

IMMUNIZATIONS AND CHEMOPROPHYLAXIS

- Influenza vaccine to prevent influenza.

- Pneumococcal vaccine to prevent pneumonia.
- Tetanus and diphtheria toxoids to prevent tetanus and diphtheria.
- Estrogen to prevent osteoporosis.
- Cholesterol-lowering drugs to prevent coronary heart disease.

Detailed information about the appropriate indications for these preventive services has emerged from a strong science base. Preventive services for the elderly have been introduced into clinical guidelines based on extensive reviews of the scientific evidence by expert panels and organizations. These include the landmark papers of Frame and Carlson in 1975 (14) and Breslow and Somers in 1977 (15); the 1979 report of the Canadian Task Force on the Periodic Health Examination (16); the 1980 American Cancer Society screening guidelines (17); the report of the American College of Physicians in 1981 (18); the American Medical Association policy statement in 1983 (19); the 1987 recommendations of the Clinical Efficacy Assessment Project of Blue Cross-Blue Shield and the American College of Physicians (20); the report of the U.S. Preventive Services Task Force (21); the 1986 four-part monograph by Frame (22); and the 1987 American Heart Association report (23). Government agencies, NIH consensus development conferences (24), and many specialty organizations have also recently issued recommendations on selected screening tests of relevance to the elderly.

The impetus for these developments is the growing body of research demonstrating that preventive interventions can be more effective in saving lives than medical therapy of symptomatic persons. These findings come as no surprise. It is intuitive, for example, that altering the nutritional habits that cause atherosclerosis is a more worthwhile investment than coronary artery bypass surgery or angioplasty. Despite the compelling logic behind primary and secondary prevention, we find that the majority of U.S. health care expenditures for the elderly are nonetheless invested in tertiary prevention (attempting to prevent the progression of a disease after the patient is already afflicted).

We can no longer afford this practice. Economic pressures have placed tight limitations on health care services for the aged. It is essential that these limited resources be directed toward those preventive health care services that are more effective in reducing the individual and societal costs of disease. This has stimulated a reexamination and abandonment of ineffective diagnostic tests that clinicians have performed routinely on older Americans at great national expense (25-28). An emphasis on prevention over expensive alternatives will become especially important in future years because a greater proportion of Americans are entering the ranks of the elderly. Persons aged 75 and older represent the fastest growing segment of our population and are expected to increase an estimated 60% by the year 2000 (29). If current practices are allowed to continue, the number of nursing home patients will double in 20 years (2). Whereas currently persons over age 65 are responsible for about 30% of health care expenditures, that figure is estimated to rise to 50% by the year 2040 (1).

Although these developments are likely to orient national health policy toward prevention, perhaps the greatest stimulus for preventive health care for older Americans is coming from society itself. Public education campaigns on cholesterol, high blood pressure, Alzheimer's disease, and many other targets of prevention are increasingly apparent on television and radio broadcasts, women's magazines, and other media. Today's elderly and their families are more knowledgeable about the benefits of health promotion and which screening tests should be performed by their physicians. Medical students are being taught the principles of geriatric prevention as are practicing physicians in their continuing medical education curricula (29). Clearly the future holds the promise of prevention for the elderly and a more efficient agenda for health care in general. The next step is to insure availability of those services to all older Americans.

REFERENCES

(1) Stults BM. Preventive health care for the elderly. West J Med 1984;141:832-845.

(2) Komaroff AL. Screening tests for nursing home patients. JAMA 1987;258:14:1941.

(3) National Center for Health Statistics: Health United States, 1986. DHHS Pub. No. (PHS) 87-1232. Public Health Service. Washington, DC: U.S. Government Printing Office, 1986.

(4) Public Health Service. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. DHHS Pub. No. (PHS) 79-55071. Public Health Service. Washington, DC: U.S. Government Printing Office, 1979.

(5) U.S. Department of Health and Human Services. The Health Consequences of Involuntary Smoking. A Report of the Surgeon General. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Office on Smoking and Health, 1986.

(6) U.S. Department of Health and Human Services. The Health Consequences of Smoking. A Report of the Surgeon General. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office on Smoking and Health, 1982.

(7) U.S. Department of Health and Human Services. The Health Consequences of Smoking. A Report of the Surgeon General. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office on Smoking and Health, 1983.

(8) American Heart Association. Eleventh Bethesda Conference: Prevention of Coronary Heart Disease. New York: Technical Publishing Company, 1981.

(9) American Cancer Society. Cancer Facts and Figures, 1987. New York: American Cancer Society, 1987.

(10) La Vecchia C, Decarli A, Gentile A, et al. Pap smear and the risk of cervical neoplasia: quantitative estimates from a case-control study. Lancet 1984; 2:779-782.

(11) Miller AB, Visentin T, Howe GR. The effect of hysterectomies and screening on mortality from cancer of the uterus in Canada. Int J Cancer 1981; 27:651-657.

(12) Lipid Research Clinics Program. The Lipid Research Clinics coronary primary prevention trial results. II. The relationship of reduction in incidence of coronary heart disease to cholesterol lowering. JAMA 1984;251:365-374.

(13) Multiple Risk Factor Intervention Trial Research Group: Multiple Risk Factor Intervention Trial: Risk factor changes and mortality results. JAMA 1982;248:1465-1477.

(14) Frame PS, Carlson SJ. A critical review of periodic health screening using specific screening criteria. J Fam Pract 1975; 2:283-9.

(15) Breslow L, Somers AR. The lifetime health-monitoring program: A practical approach to preventive medicine. N Engl J Med 1977; 292:11:601-608.

(16) Canadian Task Force on the Periodic Health Examination: The periodic health examination. Can Med Assoc J 1979; 121:1194-1254.

(17) American Cancer Society. Report on the Cancer-Related Health Checkup. CA 1980;30:194-240.

(18) American College of Physicians. Periodic Health Examination: A Guide for Designing Individualized Preventive Health Care in the Asymptomatic Patient. Ann Intern Med 1981;95:729-732.

(19) American Medical Association. Medical Evaluations of Healthy Persons. Council on Scientific Affairs. JAMA 1983; 249:12:1626-1633.

(20) American College of Physicians. Common Diagnostic Tests: Use and Interpretation. Philadelphia: American College of Physicians, 1987.

(21) Lawrence RS, Mickalide AD. Preventive services in clinical practice: Designing the periodic health examination. JAMA 1987;257:16:2205-2207.

(22) Frame PS: A critical review of adult health maintenance. J Fam Pract 1986; 23:1:29-39.

(23) American Heart Association. Cardiovascular and Risk Factor Evaluation of Healthy American Adults: A Statement for Physicians by an Ad Hoc Committee Appointed by the Steering Committee. Circulation 1987;75:6:1340A-1362A.

(24) Mullan F, Jacoby I. The town meeting for technology: The maturation of consensus conferences. JAMA 1985;254:8:1068-1072.

(25) Levinstein MR, Ouslander JG, Rubenstein LZ, et al. Yield of routine annual laboratory tests in a skilled nursing home population. JAMA 1987;258:14:1909-15.

(26) Tape TG, Mushlin AI. The utility of routine chest radiographs. Ann Intern Med 1986;104:663-670.

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ABSTRACT

This report briefly discusses selected legislation in the 100th Congress affecting the elderly. Legislation has been enacted to reauthorize the Older Americans Act through 1991, to improve the quality of nursing home and home health care, to expand certain community-based long-term care services, to permanently authorize the congregate housing program under the Department of Housing and Urban Development (HUD), and to authorize a White House Conference on Aging in 1991. Congress is also considering legislation to provide catastrophic health protection for the elderly under Medicare, and various proposals to assist persons in need of community-based long-term care and their family caretakers.

SELECTED LEGISLATION IN THE 100TH CONGRESS AFFECTING THE ELDERLY

I. INTRODUCTION

This report briefly describes selected legislation in the 100th Congress affecting the elderly. While many bills have been introduced, this report presents selected legislation which has been enacted or which has received some action.

Legislation has been enacted to reauthorize the Older Americans Act (OAA) through 1991, to improve the quality of nursing home and home health care, to expand certain community-based long-term care services, to permanently authorize the congregate housing program under the Department of Housing and Urban Development (HUD), and to authorize a White House Conference on Aging in 1991. Congress is also considering legislation to provide catastrophic health protection for the elderly under Medicare, and various proposals to assist persons in need of community-based long-term care and their family caretakers.

Many provisions affecting programs for the elderly were contained in the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203, enacted on December 22, 1987) including, for example, the Medicare, Medicaid, and Supplemental Security Income (SSI) programs. Selected provisions of this law and other legislation are briefly described below.

II. LEGISLATION ENACTED

A. Social Services under the Older Americans Act

The Older Americans Act is the major Federal program for the organization and delivery of social and nutrition services for the elderly. Authorizations of appropriations for the Act were to expire at the end of FY 1987. P.L. 100-175, the Older Americans Act Amendments of 1987, providing a 4-year reauthorization, through 1991, was enacted on November 29, 1987. The law authorized $1.5 billion in FY 1988 for all programs.

This legislation added a number of new authorizations of appropriations under the title III State and area agency on aging program to address the needs of certain populations, including the frail elderly living at home, residents of long-term care facilities, and persons at risk of abuse, neglect, or exploitation. The amendments also added new authorizations for programs of outreach to older persons who may be eligible for benefits under the SSI, Medicaid, and Food Stamp programs, and for health education and promotion activities. Other groups given special attention in various amendments to the Act were Native American elderly and the disabled. A provision was added under the Act's community service employment program to exclude wages received under the program from being considered when determining eligibility for Federal housing and Food Stamp programs.

In addition, the FY 1988 Continuing Appropriations legislation (P.L. 100-202) provided $1.2 billion for all Older Americans Act programs, including $561 million for nutrition services and $331 million for community service employment.

B. Long-Term Care

1. Improving the Quality of Care in Nursing Homes and in Home Health Care

P.L. 100-203, the OBRA of 1987, contained a number of provisions designed to improve the quality of care in nursing homes financed through Medicare and Medicaid, and in the delivery of home health services financed through Medicare. Among other things, the law revised general requirements that nursing homes must meet in order to participate in Medicare and Medicaid, and revised the survey and certification process for determining whether they meet these requirements. It also strengthened staffing and training requirements by requiring that Medicaid nursing facilities provide registered professional nursing staff coverage 7 days a week, 8 hours a day, and 24-hour licensed practical nursing staff coverage 7 days a week. (This requirement may be waived by the State under certain circumstances.) The law also required Medicare and Medicaid facilities with more than 120 beds to employ at least one full-time social worker, and required minimum standards for nursing aide training. In addition, the law specified actions to be taken by facilities to protect the rights of residents.

In addition to these Medicare and Medicaid reforms, Congress enacted legislation to strengthen the role of the State long-term care ombudsman program funded under the Older Americans Act. (This program is responsible for investigating and resolving complaints of residents of nursing homes and other adult care homes.) P.L. 100-175 added a separate authorization of appropriations to support this program (previously funded through a set aside of Older Americans Act funds or through State funds). In addition, it required ombudsmen to investigate actions, inactions or decisions of long-term care providers or their representatives, and other agencies which may adversely affect residents;

prohibited conflict of interest in designation of ombudsmen and willful interference in the performance of official ombudsman responsibilities; and protected ombudsmen from liability under State law for good faith performance of their official duties.

With respect to home health services, P.L. 100-203 contained a number of provisions to assure quality of care by amending conditions of participation for home health agencies participating under Medicare. These include provisions to protect the rights of recipients of home health care, to strengthen survey and certification procedures to assess each home health agency's compliance with Federal requirements (including requirements for on-site visits), and to specify training requirements for home health agency personnel.

2. Home and Community-Based Waiver Program for the Elderly under Medicaid

P.L. 100-203 amended a prior law provision which allowed States to provide Medicaid-supported home and community-based services to a variety of groups, including the elderly (known as the "2176" home and community-based waiver program) to create a new waiver program specific to the elderly. Under the revised waiver program for the elderly, a wide range of home and community-based services, including for example, homemaker, personal care, adult day care services, and respite care for families, will continue to be available to persons 65 years and over for whom a determination has been made that institutionalization would be required without the waivered services. The law also revised prior law requirements pertaining to payments to States for waiver services by incorporating new provisions which will aggregate payments for nursing home costs and home and community-based services costs and increase this amount in future years by a specified percentage.

3. In-Home Services Expansion under the Older Americans Act

A new program authorization for non-medical in-home services for the frail elderly was added to the Older Americans Act title III program as part of the Act's reauthorization legislation mentioned above (P.L. 100-175). This program authorizes funds to State agencies on aging to support a variety of home care services, including home health aide, homemaker, chore maintenance, in-home and adult day care respite care for families of frail elderly, and minor home modification. State agencies on aging are to develop criteria for the use of these funds taking into account factors such as age, economic need, and other factors contributing to the need for in-home services.

P.L. 100-175 authorized $25 million for this program in FY 1988; the FY 1988 appropriations level is $4.8 million.

4. Payments to Institutionalized Individuals under the Supplemental Security Income Program

a. Increase in the personal needs allowance for nursing home residents. Under the SSI program, once an eligible recipient enters a nursing home under Medicaid, the monthly SSI benefit payable to the recipient is eliminated, except for a small sum to be retained by the individual for personal needs. P.L. 100-203 increased this personal needs allowance for the first time since the enactment of the SSI program in 1974--from $25 to $30 a month for an individual, and from $50 to $60 a month for eligible couples. The law also required that States which provide supplementary payments to persons who are eligible for SSI pass through the increased Federal personal needs allowance to recipients in order to avoid a reduction in the State payment amount. This provision is effective July 1, 1988.

b. Full benefits for SSI recipients temporarily in institutions. Under current Medicaid regulations, States are given the option of allowing persons who are temporarily institutionalized (up to 6 months) to retain more than the allowable personal needs allowance if the State determines that more money is needed to maintain a home to which the persons will return. P.L. 100-203 provided that institutionalized persons may retain their full SSI benefits, including State supplementary payments, if it is determined that the institutional stay will not exceed 3 months and they will return to the home when leaving the institution. This provision is effective July 1, 1988.

C. Housing

The Housing and Community Development Act of 1987, the first major reauthorization of Federal housing programs since 1983, authorized $621.7 million in FY 1988 and $630 million in FY 1989 for section 202 housing for the elderly and handicapped. It also made permanent the congregate housing program for the elderly which, under prior law, was a discretionary authority under HUD. The law authorized $10 million for this program for each of FYs 1988 and 1989. Another provision allows public housing agencies to give priority, in elderly housing admission policies, to near elderly families (in which the head of household or spouse is at least 50 years but below 62 years) if there are insufficient numbers of elderly families to fill housing vacancies.

In addition, the Secretary of HUD is required to conduct a study of the extent to which elderly persons in federally assisted housing are at risk of institutionalization and to assess Federal, State, and local resources which can support congregate housing services. The Secretary is also authorized to conduct a demonstration program designed to evaluate the need and demand among elderly homeowners for mechanisms to convert equity in their homes into liquid assets to meet health, housing, and subsistence costs.

D. Other Legislation

1. White House Conference on Aging

Legislation was enacted authorizing the President to call a decennial White House Conference on Aging in 1991 (P.L. 100-175). The Conference is intended to bring together representatives of Federal, State, and local governments, persons working in the field of aging, and the general public, particularly older persons, with the purpose of increasing awareness of the contributions of older persons while at the same time identifying issues affecting them and making recommendations as to ways to resolve problems.

2. Pension Plans

P.L. 100-203 contained a number of changes relating to the funding of private pension plans, including the imposition of new minimum funding standards on all single-employer defined benefit pension plans, increasing the annual per-participant premium charged for single-employer defined benefit plans by the Pension Benefit Guaranty Corporation (PBGC), increasing an employer's liability in the event of plan terminations, and imposing certain restrictions on employers who wish to recapture assets in overfunded pension plans.

3. Adult Day Care Facilities: Availability of Nutrition Funds under the National School Lunch Act

The National School Lunch Act was amended by P.L. 100-175 to permit adult day care programs to receive reimbursement under the Child Care Food program for meals or meal supplements (snacks) to persons 60 years or older or to chronically impaired disabled persons. (Previously the Child Care Food program provided funds for food service only to children in child care centers and family and group day care homes.)

III. LEGISLATION PENDING

A. Catastrophic Health Insurance Protection under Medicare

Bills to provide protection against catastrophic health costs for the elderly have been passed by both the House and the Senate (H.R. 2470, as passed by the House July 22, 1987 and by the Senate October 27, 1987). Although the bills differ in various respects, both would provide catastrophic protection for enrollees in Medicare Part B (Supplementary Medical Insurance) by limiting beneficiary cost-sharing liability, removing coinsurance for covered hospital services, eliminating length of hospital stay requirements, extending the number of days of skilled nursing facility (SNF) coverage, eliminating the requirement for a 3-day prior hospitalization prior to SNF coverage, and expanding home health services. Both bills would establish a separate catastrophic prescription drug program which would pay 80 percent of the costs of outpatient prescription drugs after a beneficiary had met the deductible.

Both bills would establish an annual out-of-pocket limit on beneficiary expenses. The House bill would provide a $1,043 limit on Part B (Supplementary Medical Insurance) expenses in 1989 to be indexed by the annual social security cost-of-living adjustment in future years. The Senate bill would provide a limit of $2,030 in 1989 on expenses for both Parts A and Part B (Hospital and Supplementary Medical Insurance) indexed by a factor to ensure that the same percentage of enrollees reach the limit in future years as did in 1989. Both bills would be financed through a combination of income-related premiums for those with tax liability and an increase in the Part B premium.

Although both bills would modify nursing home and home health coverage provisions under Medicare, they would not significantly expand long-term care services.

B. Long-Term Care

1. Spousal Improverishment under Medicaid

The issue of spousal impoverishment has been addressed by various bills introduced in the 100th Congress. (Under current Medicaid policy, in order to establish eligibility for nursing home coverage, individuals must deplete their income and resources down to specified amounts before payment under Medicaid may be made. This can have the effect of impoverishing a person whose spouse is in a nursing home, known as "spousal impoverishment.") Both the House- and Senate-passed versions of proposals to provide catastrophic health insurance for the elderly (H.R. 2470) contain amendments which would make the current Medicaid policies less restrictive. Although the bills differ in certain respects, both would allow the spouse of an institutionalized resident to keep income for maintenance needs in amounts exceeding the poverty line up to a level of $1,500 a month.

2. Expansion of Home Health Services under Medicare

A number of bills have been introduced to expand and/or modify Medicare's home health care benefit. One bill, H.R. 3436, which has been reported by the Committee on Education and Labor, would significantly expand home care services under Medicare. (As reported by the Committee on Education and Labor, H.R. 3436 contained technical amendments to the Older Americans Act. In considering the rule for H.R. 3436, the Committee on Rules substituted language amending Medicare.) This bill would add to Medicare coverage, long-term home care benefits for chronically ill individuals, including the elderly, disabled, and children. Home care benefits to be covered would include nursing care, homemaker/home health aide services, medical social services, medical supplies, and patient and caregiver education, training, and counseling. The cost of the expanded home care services would be controlled by limiting reimbursement to a fixed percentage of nursing home costs. The proposal would establish as the financing source for the program, taxes accruing from the elimination of the cap on income which is subject to the Medicare payroll tax.

3. Assistance to Family Caregivers of Disabled Elderly

A number of bills have been introduced to offer support to family caregivers of the disabled elderly in need of long-term care. One proposal is included in the House-passed version of the catastrophic health insurance proposal (H.R. 2470). This proposal would amend the current Medicare program to provide up to 80 hours a year of in-home benefits for chronically dependent persons as a respite for unpaid individuals who live with and care for such persons. Under this proposal, the benefit would expire in 1991. A different approach to assisting families is contained in the Family and Medical Leave Act as reported by the Committee on Education and Labor (H.R. 925, ordered reported November 17. 1987). This bill would entitle employees up to 10 weeks of unpaid family leave to care for an ill parent and would apply to employers with more than 50 employees.

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Reproduced from U.S. Congress. House. Committee on the Budget. President Reagan's fiscal year 1989 budget; a summary and analysis prepared by the staff of the House Budget Committee. Washington, G.P.O., 1988. p. 85-86, 61.

D. Older Americans

Persons who are 65 years of age or older are affected by a number of government programs, including social security, medicare, medicaid, retirement, veterans' assistance, and housing. In addition, the elderly like other Americans are affected by all budget and economic policies.

The elderly are an increasingly larger proportion of the population. Currently, there are almost 30 million persons 65 years of age or older and they are 12.1 percent of the U.S. population. Not only are the aged increasing faster as a proportion of the population than any other group, but the older aged are increasing the fastest of all. By the turn of the century, projections indicate that elderly persons will be almost 13 percent of the population and those over 85 will be 1.8 percent of the population compared to 1 percent at the present time.

Like most Americans, the elderly have great variation in their economic resources. In the aggregate they fare well compared to the total population when factors such as poverty are considered. In 1986, for example, the elderly poverty level was 12.4 percent compared to 13.6 percent for all persons. However, these aggregates may tend to mask significant pockets of poverty which continue among elderly women and minorities as shown in the table below. In addition, conditions worsen for the older elderly persons and for those who live alone.

POVERTY LEVELS FOR THE ELDERLY AND
TOTAL U.S. POPULATION
(1986)

Group	Poverty Rate
Total Population	13.6
Elderly	
All Elderly	12.4
Black Elderly	31.0
Hispanic Elderly	22.5
Female Elderly	15.2
Black Female Elderly	35.5

Social security has played a major role in helping to improve the economic condition of the elderly. Cost of living increases have enhanced the abilities of many older persons to keep up with inflation. In this regard, a COLA of 4.2 percent was awarded in January 1988 and the President's budget has proposed that another 4.2 percent increase be allowed in January 1989. The budget does not propose any benefit changes in social security for 1989.

The budget includes funding and policy changes for the following programs which are of special interest to the elderly:

Medicare:

The President's budget requests $84.00 billion in outlays for medicare for fiscal year 1989 to provide health care for 30 million elderly and 3 million disabled persons. This funding level assumes savings of $1.25 billion. The budget proposes that the savings be achieved through reductions in medicare hospital payments for indirect and direct medical education; reductions in payments to physicians for anesthesiology and radiology services and for certain overpriced surgical and other medical care. In addition, medicare payments for home dialysis services, durable medical equipment, and some other medical supplies and products will be reduced. The President's budget also proposes to increase peer review and other activities designed to improve and monitor the quality of medical care. Under the budget proposals, the requirement that medicare premiums cover 25 percent of program costs would become permanent in 1990. This provision currently is scheduled to expire at the end of 1989. The budget supports the Senate-passed version of catastrophic health insurance. This legislation would impose a cap on the total out-of-pocket amount which a beneficiary would have to pay for medicare covered services and it would eliminate all beneficiary payments for inpatient hospital services except the first day deductible. The budget also would require all State and local workers to contribute to the medicare hospital insurance payroll tax.

Medicaid:

The budget proposes regulatory savings of $0.40 billion in 1989. Of the 25 million medicaid recipients, approximately 15 percent are aged, yet nearly 40 percent of medicaid payments go for services for the aged. Because of age and disability, this group requires more acute and long-term care, which accounts for the disproportionate share of medicaid payments. Therefore, any reductions in Federal medicaid funding could have a particularly adverse impact on the poor elderly.

Section 202 Housing for the Elderly or Handicapped:

This program provides loans to nonprofit organizations to finance the construction of housing for lower-income elderly and handicapped tenants who are participating in the HUD Section 8 housing program. The President's 1989 budget proposes to decrease new section 202 loans from $566 million in 1988, which will support an estimated 11,500 units, to $350 million in 1989, which will support an estimated 7,000 new units. This proposal is consistent with the administration's plan to substitute housing vouchers for most other forms of low-income housing assistance.

Older Americans:

The budget proposes $336 million in 1988 for community service employment for older Americans under the Department of Labor. This is $5 million more than provided in 1988. The President proposes an appropriation of $725 million for Administration on Aging programs which is the same amount provided in 1988.

MAJOR ENTITLEMENT PROGRAMS
(Outlays in billions of dollars)

	1988	1988	1989	President's 1989 Request			1989 Differences
	CBO Baseline (1/21/87)	President's Request (2/18/88)	CBO Baseline (1/21/87)	Current Services	Proposed Change	Net Program Costs	President over(+)under(-) CBO Baseline
A. LOW-INCOME							
Medicaid	30.55	30.65	34.25	33.15	-0.40	32.75	-1.50
Food Stamps	13.20	13.45	13.75	13.40	...	13.40	-0.35
Family Support Payments:							
AFDC & Child Support	10.85	10.80	11.40	10.75	0.15	10.95	-0.45
SSI	12.75	12.65	12.70	12.50	...	12.50	-0.20
Veterans' Pensions	3.75	3.85	3.70	3.85	...	3.85	0.15
Child Nutrition	4.40	4.40	4.65	4.70	...	4.70	0.05
Earned Income Tax Credit	2.95	2.90	4.15	3.90	...	3.90	-0.25
Vocational Rehabilitation State Grant	1.35	1.35	1.40	1.40	-*	1.40	-*
SUBTOTAL LOW-INCOME	79.80	80.05	86.00	83.65	-0.25	83.45	-2.55
B. SOCIAL SECURITY	219.05	219.70	234.00	233.75	...	233.75	-0.25
C. UNEMPLOYMENT COMPENSATION	17.00	15.75	17.95	16.50	-0.10	16.40	-1.55
D. MEDICARE	80.00	78.85	87.10	85.25	-1.25	84.00	-3.10
E. RETIREMENT & DISABILITY							
Civil Service Retirement	27.00	27.55	29.00	29.55	...	29.55	0.55
Military Retirement	19.05	19.15	20.25	20.30	...	20.30	0.05
Veterans' Compensation	10.70	10.35	11.05	11.00	...	11.00	-0.05
Railroad Retirement	6.45	7.20	6.70	7.25	...	7.25	0.55
SUBTOTAL RETIREMENT & DISABILITY	63.20	64.25	67.00	68.10	0.00	68.10	1.10
F. OTHER PROGRAMS							
Farm Price Supports	17.25	17.65	17.40	17.10	...	17.10 **	-0.30
Veterans' Readjustment Benefits	0.40	0.45	0.35	0.45	-*	0.45	0.10
Guaranteed Student Loans	2.65	2.65	3.15	2.75	...	2.75 **	-0.40
Foster Care/Adopt. Asst.	1.05	1.00	1.05	0.95	0.05	1.00	-0.05
Social Services (Title XX)	2.75	2.70	2.70	2.70	...	2.70	...
SUBTOTAL OTHER PROGRAMS	24.10	24.45	24.65	23.95	0.05	24.00	-0.65
	=======	=======	=======	=======	=======	=======	=======
TOTAL	483.15	483.05	516.70	511.20	-1.55	509.70	-7.00

* Less than $25 million.

** Excludes estimated subsidy costs for new loan guarantees associated with the President's credit reform proposal.

Reproduced from Alien eligibility requirement for major Federal assistance programs, by Joyce Vialet. Washington, Congressional Research Service, 1986, p. 1-6. (CRS Report no. 86-49)

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ALIEN ELIGIBILITY REQUIREMENTS FOR MAJOR FEDERAL ASSISTANCE PROGRAMS

I. BACKGROUND

Most Federal assistance programs permit benefits to be provided to aliens, although distinctions are made depending on an alien's status in the United States. Aliens who are lawful permanent residents (i.e., immigrants) are entitled to most of the same benefits available to citizens. Aliens admitted temporarily as nonimmigrants, and those in the United States illegally, are generally denied benefits. However, even these two groups may participate in some government programs which do not restrict eligibility to citizens and permanent residents.

Prior to 1972 the Federal Government's major public assistance programs providing Federal funds for State and local welfare programs contained no eligibility requirement regarding citizenship or an alien's status in the United States. Instead, State governments were permitted to establish citizenship or residence requirements for participation in their programs. A number of States enacted laws denying various types of public assistance to all aliens or to aliens who had not resided in the United States for a fixed number of years. 1/ However, in 1971 the Supreme Court in Graham v. Richardson 2/ declared such State

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1/ Carliner, David. The Rights of Aliens: The Basic ACLU Guide to an Alien's Rights. New York, Avon Books, 1977. p. 159.

2/ 403 U.S. 365 (1971). More recently, the U.S. Supreme Court declared that it was unconstitutional for the States to bar children from schools on the basis of their alien status, Plyler v. Doe, 457 U.S. 202 (1982).

statutes unconstitutional, both because they violate the Equal Protection Clause of the 14th amendment, and because they encroach upon the exclusive Federal power over the entrance and exclusion of aliens.

In a footnote to the Graham opinion, the Court stated that it had no occasion at that time to decide whether Congress, in the exercise of the Federal immigration and naturalization power, could enact statutes imposing residency requirements on aliens as a condition of federally funded welfare benefits. 3/ That question was answered in 1976 when the Court in Mathews v. Diaz 4/ approved a congressionally imposed 5-year residency requirement for aliens to participate in the Medicare Supplementary Insurance (part B) program. In doing so, the Court declared that it is "obvious that Congress has no constitutional duty to provide all aliens with the welfare benefits provided to citizens." 5/

Following Graham v. Richardson, on June 16, 1972, regulations to implement that decision were proposed by the Social and Rehabilitation Service of the Department of Health, Education and Welfare. The proposed regulations stipulated that State plans under the Aid to Families With Dependent Children (AFDC) and Medicaid programs "may not exclude an otherwise eligible individual on the basis that he is not a citizen, or because of his alien status." 6/ Public response was heavily against these proposed regulations because they would have granted assistance to aliens who have not been lawfully admitted to the United States. Reasons for the objections included the belief that the Graham decision was not

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3/ Id. at 382, n. 14.

4/ 426 U.S. 67 (1976).

5/ Id. at 82.

6/ 37 F.R. 11977, June 16, 1972.

applicable to illegal aliens; that caseloads would be increased beyond the fiscal capability of the States; and that assistance to such aliens should be entirely federally financed because of the Federal Government's responsibility for immigration and naturalization.

While the AFDC and Medicaid regulations were still pending, in October of 1972, Congress established a statutory alien eligibility requirement for the new Supplemental Security Income (SSI) for the Aged, Blind and Disabled program. 7/ Assistance under that program was limited to U.S. residents who are either (1) citizens or (2) aliens lawfully admitted for permanent residence or otherwise residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 203(a)(7) or section 212(d)(5) of the Immigration and Nationality Act). 8/

On June 27, 1973, the proposed regulations on citizenship and alienage for the AFDC and Medicaid programs were withdrawn. On November 2, 1973, revised regulations were adopted for the two programs with an alien eligibility requirement identical to the statutory requirement for the SSI program. In 1981, alien eligibility for AFDC, virtually unchanged, was established by statute (see page CRS-7).

The eligibility of aliens other than those lawfully admitted for permanent residence to participate in SSI, AFDC and Medicaid has depended largely upon the

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7/ Social Security Amendments of 1972; Act of Oct. 30, 1972; P.L. 92-603; 86 Stat. 1329.

8/ 42 U.S.C. 1382c. The citations to the Immigration and Nationality Act refer, respectively, to refugees (now sections 207 and 208 of the Immigration and Nationality Act, as amended by the Refugee Act of 1980, P.L. 96-212), and to parolees admitted at the discretion of the Attorney General.

meaning of the phrase "under color of law." The SSI legislation and Medicaid regulations specifically state that the phrase includes refugees and parolees; the AFDC legislation additionally includes persons granted asylum. The legislative history of the language in the SSI legislation indicates that the phrase "under color of law" was intended also to include certain aliens who entered the United States prior to July 1948, who were not originally lawfully admitted for permanent residence, but who since have been issued certificates of lawful admission by the Attorney General. 9/ The U.S. Court of Appeals for the Second Circuit, in the case of Holley v. Lavine, 10/ construed the phrase to include not only the specified categories, but also deportable aliens whose deportation the Immigration and Naturalization Service (INS) has indefinitely deferred. The case before the Court involved an alien who had received written assurance from the INS that she would not be deported, at least until her children, who were U.S. citizens, were fully grown. The court ruled that by virtue of INS' exercise of discretion not to enforce the alien's departure, she was an alien permanently residing in the United States "under color of law," and hence was eligible for AFDC benefits.

Because of the indefiniteness of the "under color of law" language, and also because of concern over Administration proposals to grant amnesty to illegal aliens, the alien eligibility requirement for another Federal assistance program--the Food Stamp program--was altered by statute in 1977. Previously an alien eligibility requirement identical to that of the SSI, AFDC and Medicaid programs had been contained in regulations adopted by the Food and Nutrition Service of the Department of Agriculture in July of 1974. However, with passage of the Food

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9/ S. Rept. 92-1230 (Sept. 26, 1972), p. 466.

10/ 553 F.2d 845 (2d Cir. 1977).

Stamp Act of 1977, 11/ Congress replaced the "under color of law" language with an exclusive statutory list of aliens eligible for participation in the Food Stamp program. The enumerated categories of eligible aliens include: (1) those lawfully admitted for permanent residence as immigrants; (2) those who entered the United States prior to July 1948 who were not originally lawfully admitted for permanent residence, but who have been issued certificates of lawful admission by the Attorney General; (3) refugees; (4) those who are paroled into the United States temporarily by the Attorney General; and (5) those who have been permitted to remain in the United States because the Attorney General has withheld deportation to countries in which the aliens would be subject to persecution on account of race, religion, or political opinion. The accompanying House report indicated that the intent of the statutory list was "to eliminate the possibility that a Presidential pardon of potentially millions of illegal aliens would render them eligible for food stamps or that judicial stays of deportation, whether wholesale or individualized, would permit illegal aliens to participate." 12/

Most alien eligibility requirements for Federal assistance programs are aimed at denying participation by nonimmigrant and undocumented aliens, rather than at limiting participation by permanent resident aliens. However, as a result of perceived abuses of the SSI program by some newly-arrived immigrants, 13/ Congress in 1980 passed legislation restricting somewhat the availability of SSI benefits. 14/ Under the new law, any immigrant who has entered the country with

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11/ Act of Sept. 29, 1977; P.L. 95-113; 91 Stat. 966.

12/ H. Rept. 95-464 (June 24, 1977), p. 148.

13/ U.S. Comptroller General. Number of Newly-Arrived Aliens Who Receive Supplemental Security Income Needs to be Reduced. Washington, General Accounting Office, 1978. 24 p.

14/ Act of June 9, 1980; P.L. 96-265, 94 Stat. 441.

an agreement by a U.S. sponsor to provide financial support, and who subsequently applies for SSI benefits, will be deemed for a period of 3 years after entry to have the income and resources of his sponsor available for his support. Newly-arrived aliens who become blind or disabled after their arrival in the United States, and refugees and asylees, are not affected by the Act. During 1981 Congress enacted similar "deeming" provisions for immigrants under both the AFDC and food stamp programs.

Concern has also been expressed about perceived abuses of the Social Security system by aliens who worked in the U.S. just long enough to earn the minimum number of quarters required before returning to their native countries where, it is contended, many married and had children. In such cases, it was argued, the aliens could collect social security benefits for themselves and their dependents for years, the benefits quickly exceeding the relatively small amounts contributed. Moreover, in such cases the dependents receiving benefits had no U.S. ties and had not been dependent on the worker's earnings while he worked in covered employment in the U.S. 15/ In the 98th Congress, legislation was enacted which includes provisions restricting the eligibility for social security benefits of certain non-resident alien dependents or survivors and providing that a tax of 15 percent of a non-resident alien's social security benefits be withheld beginning in 1984. 16/

15/ U.S. General Accounting Office. Issues Concerning Social Security Benefits Paid to Aliens. U.S. General Accounting Office, Wash., D.C., Mar. 24, 1983. Rept. No. HRD-83-32.

16/ Social Security Amendments of 1983; Act of Apr. 20, 1983; P.L. 98-21; 97 Stat. 65.

RESOLVED:

THAT THE FEDERAL GOVERNMENT SHOULD IMPLEMENT A COMPREHENSIVE PROGRAM TO GUARANTEE RETIREMENT SECURITY FOR UNITED STATES CITIZENS OVER AGE 65.

Reproduced from Economic status of the elderly, by Brian W. Cashell. Washington, Congressional Research Service, 1988. p. 1-4. (CRS Report no. IB87095)

SUMMARY

The age distribution of the Nation's population is changing. An increasing proportion of the population is aged 65 and over. The Federal Government already has in place substantial programs designed to ensure the economic health of the elderly. Policy decisions regarding the appropriate level of those programs are likely to recur.

Over the past 18 years, there has been little real increase in aggregate household income, although elderly households have fared well. Between 1967 and 1985, over-65 households have, on average, experienced a 49% increase in their real money income. There are two major factors contributing to this relative improvement in elderly incomes. First, there has been a large increase in Social Security payments over this period. Second, the late seventies and early eighties were a time of high interest rates. Since a large share of elderly incomes is property income, elderly incomes benefitted from higher interest rates.

Since 1967, the overall pattern of income distribution has grown increasingly unequal. Here again the elderly population has bucked the trend. The distribution of elderly incomes over the past two decades has grown increasingly equal. The degree of inequality in the distribution of elderly incomes is now roughly equal to that of the population at large.

Elderly incomes also seem to be less sensitive to the fluctuations in economic growth that occur over the course of the business cycle. Compared to the rest of the population, the elderly receive a smaller share of their income from wages and salaries. Thus, the ups and downs of the labor market have a relatively smaller effect on elderly incomes. Social Security payments make up the largest share of elderly incomes, followed by income from property.

The elderly are also among the wealthiest in the population. Nearly a third of the elderly households have a net worth greater than $100,000. Three-fourths of the elderly own their own homes. Home equity makes up the largest share of elderly wealth, although it is less important than for other age groups.

The share of elderly persons defined as living below the poverty threshold has declined over the past ten years. In 1982, for the first time since poverty measures have been reported, the elderly poverty rate fell below the overall poverty rate.

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ISSUE DEFINITION

A substantial share of Federal outlays are for programs designed to benefit the elderly population. Whether or not to increase those efforts is likely to depend on the perceived economic health of the elderly.

BACKGROUND AND ANALYSIS

In 1985, those aged 65 and over constituted 12% of the total population. That ratio is projected to rise to 13% by 2000 and to continue increasing. Thus, the importance of the elderly population is likely to increase.

Although the share of elderly in the population is growing, the elderly constitute a declining share of the labor force. In the late 1940s over 25% of the labor force was aged 65 and over. By 1985, that proportion was just over 10%. In part, this reflects an increase in overall living standards which has allowed a greater number of elderly to retire. In addition, the increased income security provided by Social Security has probably also played a role in this trend.

In 1985, the median income among elderly households was $13,254, compared to median income for all households of $23,618. Over the past fifteen years, elderly incomes have grown in real terms while those of the rest of the population have stagnated. Between 1967 and 1985, the median household income among the elderly grew by 49%, adjusted for inflation. Real median income for all households was virtually unchanged over the same period. There are two major explanations for the large difference in real income growth. First, there has been a large increase in Social Security payments. In 1984, 41.3% of elderly income derived from Social Security and Railroad retirement. Thus, changes in Social Security benefits can have a large effect on elderly incomes. Second, recent high interest rates have also tended to boost elderly incomes. In 1984, property income constituted 26.5% of elderly income. Interest rate fluctuations can have a significant effect on elderly incomes.

TABLE 1. Median Household Income, 1967-1985

	All households			Over-65 households		
	current $	constant 1985 dollars		current $	constant 1985 dollars	
		1985 $	% change		1985 $	% change
1967	$ 7,143	$ 23,015		$ 2,760	$ 8,893	
1968	7,743	23,942	4.0%	3,180	10,138	14.0%
1969	8,389	24,617	2.8	3,329	9,769	-3.6
1970	8,735	24,197	-1.7	3,498	9,691	-0.8
1971	9,028	23,980	-0.9	3,813	10,128	4.5
1972	9,697	24,935	4.0	4,169	10,720	5.9
1973	10,512	25,447	2.1	4,583	11,094	3.5
1974	11,197	24,426	-4.0	5,292	11,544	4.1
1975	11,800	23,585	-3.4	5,919	11,831	2.5
1976	12,686	23,973	1.7	5,962	11,267	-4.8
1977	13,572	24,093	0.5	6,347	11,267	0.0
1978	15,064	24,839	3.1	7,081	11,676	3.6
1979	16,461	24,396	-1.8	7,879	11,677	0.0
1980	17,710	23,128	-5.2	8,781	11,467	-1.8
1981	19.074	22,561	-2.5	9,903	11,713	2.2
1982	20,171	22,480	-0.4	11,041	12,305	5.1
1983	21,018	22,694	1.0	11,972	12,927	5.1
1984	22,415	23,215	2.3	12,799	13,256	2.6
1985	23,618	23,618	1.7	13,254	13,254	0.0

Source: Department of Commerce, Bureau of the Census; Department of Labor, Bureau of Labor Statistics.

The increased importance of Social Security to elderly incomes has affected the elderly in other ways. Because Social Security payments are capped, and because earnings replacement is higher for low-wage individuals, those payments tend to have an equalizing effect on elderly incomes. In fact, while overall inequality in the income distribution has been on the rise, inequality in the distribution of elderly incomes has been on the decline.

Elderly incomes seem to vary less over the course of the business cycle compared to the overall population. First, because a relatively smaller share of elderly income comes from wages and salaries, they are less affected by increases in unemployment that occur during recession. Furthermore, Social Security benefits do not rise and fall over the course of the business cycle. Since those benefits make up a large share of elderly incomes, they tend to stabilize elderly incomes over the course of the business cycle.

The relative gains in elderly incomes are also reflected in measures of poverty. In 1959, the poverty rate for the elderly population was 35.2%, compared to an overall poverty rate of 22.4%. Since that time, the poverty rate for the elderly has trended steadily downwards. In 1982, for the first time, the elderly poverty rate dropped below the overall poverty rate and has remained there since. In 1985, the poverty rate for persons aged 65 and over was 12.6%, compared to an overall rate of 14.0%.

The elderly are substantially wealthier than is the population at large. In 1984, the median net worth among elderly households was $$60,266, compared to an overall median net worth of $32,667. Nearly a third of elderly households had a net worth of over $100,000 in 1984, compared to about a fifth of all households.

The composition of net worth varies substantially by age. Home equity is the most important component of wealth for all age groups but is less so for the elderly. Nearly three-fourths of elderly households own their homes. The older a household is, the larger is the share of net worth held in interest bearing accounts. Nearly 30% of elderly net worth is held in interest earning assets.

Whether or not the standard of living of the elderly is considered adequate is likely to be a source of continued debate. There is little doubt that the economic well-being of the elderly has improved substantially in recent years, both in absolute terms and relative to the rest of the population. Increases in Social Security have clearly been responsible for some of these gains. But, the high interest rates of the early 1980s may also have provided a boost to elderly incomes.

Both of these factors, Social Security and interest rates, may be affected by major efforts to reduce future Federal budget deficits. First, Social Security benefits may not continue to grow as rapidly as they have in the past. Second, reduced @deficits could lead to lower interest rates which would tend to reduce a major source of income to the elderly. Past trends described here will not necessarily continue.

FOR ADDITIONAL READING

U.S. Library of Congress. Congressional Research Service. Economic status of the elderly population [by] Brian W. Cashell. [Washington] 1987. 11 p.
CRS Report 87-101 E

----- Proposals in the FY 1987 budget on selected programs affecting the elderly [by] Jeanne Griffith. [Washington] 1986. 31 p.
CRS Report 86-670 EPW

----- Tax Code changes of interest to aged Americans: selected provisions of the conference agreement on H.R. 3838, the Tax Reform Act of 1986 [by] Louis Allan Talley. [Washington] 1986. 5 p.
CRS Report 86-884 E

Reproduced from Four questions about national retirement income security, by Rich Hobbie, Geoffrey Kollman, and Ray Schmitt. Washington, Congressional Research Service, 1988. 19 p. (CRS report 88-242 EPW)

* FOUR QUESTIONS ABOUT NATIONAL RETIREMENT INCOME SECURITY

SUMMARY

This paper provides a framework for discussion of four topics selected by the House Committee on Ways and Means for analysis: (1) What is retirement? (2) What are the major sources of retirement income? (3) How can we define adequate retirement income? (4) What role does Federal tax policy play in retirement income security?

The definition of retirement takes on different meanings depending on whether it is observed from the perspective of individuals or of programs. In effect, the concept of retirement in the United States has been tailored, individually, to fit the specific populations that the programs, tax incentives, or regulatory criteria are designed to serve. While there has been a trend toward "early retirement," policies have been developed that encourage, permit, or require people to work longer. Virtually, all vestiges of mandatory retirement have now been eliminated.

The popular notion of a "three-legged stool" underscores the concept of social security, pensions, and asset income working together to provide retirement income. In addition, many newly retired individuals have added a fourth leg, namely, earnings from another job. Recent retirees commonly possess pension or asset income, but social security remains the main retirement income component for most individuals. While 90 percent of all civilian workers are

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covered by social security, about 2 out of 3 are covered by an employer-sponsored pension plan. The favorable tax treatment of these pension plans costs the Treasury about $60 billion in lost revenue.

How much retirement income is "adequate" is a question subject to conjecture; what income is "desirable" is still another. However, it has been estimated that retirees need to replace 51 to 86 percent of before-tax final earnings to maintain their standard of living, depending on income and marital status.

INTRODUCTION

On March 1, 1985, Chairman Dan Rostenkowski announced that the House Committee on Ways and Means was beginning a comprehensive review of national retirement income policy and that the Subcommittees on Social Security and Oversight had been directed to gather the information necessary for the Committee to conduct such a review. Over the years numerous commissions, organizations, and experts have argued that, while retirement income issues have been addressed individually, there is a need for a declared overall guiding retirement income policy that takes social security, pensions and personal savings into consideration in a coordinated and comprehensive way. On the other hand, some argue that we already have an implicit retirement income policy, or that even if an implied policy is lacking, this is desirable because individual preferences and conditions differ so greatly and change over time.

On July 18, 1985, at the first of several hearings, a number of retirement income experts addressed the four topics the Committee selected for analysis: (1) What is retirement? (2) What are the major sources of retirement income? (3) How can we define adequate retirement income? (4) What role does Federal tax policy play in retirement income security? This paper was originally prepared at the request of the Committee to provide a framework for discussion of these four questions.

WHAT IS RETIREMENT?

As elementary as it seems, the first question that arises in examining national retirement income policy is "what exactly is retirement?" The definition of retirement takes on different meanings depending on whether it is observed from the perspective of individuals or of programs. To individuals, retirement may mean ceasing work, or working irregularly or part-time. To a pension plan, retirement may mean only ceasing to work for a particular employer after becoming vested for benefits.

The social security program pays full retirement benefits at age 70 regardless of whether a person ceases to work. For individuals under age 70, social security in effect defines full retirement as earning less than a certain amount after attaining the earliest retirement age of 62. By withholding one dollar in benefits for each two dollars in earnings above certain "exempt amounts," 1/ social security also incorporates a concept of "partial retirement," in which only a portion of full retirement benefits are paid. Thus, earnings from work, along with private pensions and savings, can provide a limited supplement to social security.

Implicitly, the earnings test approach suggests that if one earns more than the exempt amount, he or she is not fully retired or, if the earnings are high enough, not retired at all. However, it is possible for one to work full time at low earnings and still draw full retirement benefits, e.g., an individual aged 65-69 earning the minimum wage. In essence, the social security earnings test represents a compromise between the social objectives of paying benefits only to those assumed to have encountered a loss of earnings (presumed to

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1/ In 1988, $6,120 for individuals under 65, $8,400 for those aged 65-69.

be due to curtailed work activity), while maintaining some incentive for older people to work if they wish to do so.

So what is retirement? Leaving a job? Drawing a pension? Does leaving a job with a particular employer and thereby qualifying for a pension constitute "retirement" if one goes to work full time for someone else or opens his own business? If not, is it leaving the work force? Reaching a certain age? Drawing full social security benefits? Are people on permanent disability retired?

The Government, as an entity, has not adopted a uniform concept of retirement. Persons leaving military service after 20 years receive half pay. Civil servants with at least 30 years' service receive unreduced retirement benefits at age 55. Most public employees may retire at any age with 30 years' service. Many union workers may also retire at any age under "30 and out" provisions. Most private sector workers may retire at age 55, although with reduced benefits. Some companies provide supplements to early pension benefits until social security benefits can begin at age 62. In effect, the concept of retirement has been tailored, individually, to fit the specific populations that the programs, tax incentives, or regulatory criteria are designed to serve.

While there is a trend towards "early retirement," policies have been developed that encourage, permit or require people to work longer. The retirement age for full benefits under social security, which has always been age 65, will gradually rise to age 67 by the year 2027. Congress has amended the Age Discrimination in Employment Act to eliminate mandatory retirement at age 70. Pension plans are also now required to continue to provide pension credit for service past age 65. Thus, virtually all official vestiges of mandatory retirement have been removed. (There are some exceptions for occupations in which public safety is at risk.)

There also are demographic and economic considerations that will affect the concept of "retirement" in the future. In the next century, the ratio of persons age 65 and over to persons of working age is projected to climb, from 20 per hundred today, to 40 per hundred by 2030 and beyond. It has been observed that the U.S. economy may find it difficult to support such a large population drawing retirement benefits of one sort or another, so it has been suggested that inducing older people to work longer will reduce this problem. Also, it has been posited that this shift in age distribution of the population may create labor shortages, which could be alleviated by encouraging older people to be part of the work force.

Improvements in health and longevity also can influence what constitutes "retirement." For example, life expectancy at age 65 now is 14.7 years for males and 18.9 years for females; by 2000 it is projected to be 15.6 and 20.1 years; by 2020, 16.3 and 21.0 years, respectively. There has been much discussion about the degree to which such improvements can or should lead to increased participation of the elderly in the work force.

The 1983 Social Security Amendments mandate several changes in the way "retirement" will be treated in the future. As noted earlier, the age at which full retirement benefits can be paid will rise gradually beginning in the next century, reaching age 67 in 2027. Benefits will be reduced by 30 percent for "retirement" at age 62 (instead of by 20 percent). Beginning in 1990, the earnings test benefit withholding rate will decrease to one dollar for each three dollars of excess earnings for people who attain the full retirement benefit age, and the so-called "delayed retirement" credit will be increased gradually for people who delay receiving benefits to an advanced age.

In sum, the concept of retirement is not clear cut. While there may be a general perception that the term means ceasing to work and drawing a pension, prevailing practices and the law provide wide variations of the notion of "retirement."

WHAT ARE THE SOURCES OF RETIREMENT INCOME?

The popular notion of a "three-legged stool" of retirement income underscores the concept of social security, pensions and asset income working together to provide retirement income. In addition to these three traditional retirement income sources, many newly retired individuals have added a "fourth leg" to the retirement income stool, namely, earnings from another job. In an article appearing in the January 1985 Social Security Bulletin, Linda Drazga Maxfield and Virginia P. Reno present data on income received by newly retired individuals. 2/ About 44 percent of married couples and 27 percent of unmarried individuals receiving social security benefits reported income from earnings.

Looking at new retirees provides a picture of how retirement income programs are working today and how they have changed over the years. The article --"Distribution of Income Sources of Recent Retirees"--shows that recent retirees commonly possess pension or asset income to supplement social security. Moreover, in the past decade the rate of pension receipt among new social security retired beneficiaries has increased dramatically. Today 56 percent of married couples and 42 percent of unmarried individuals have pension income. However, the article finds that up through the middle of the income distribution, social security remains the main retirement income component.

2/ Maxfield, Linda Drazga, and Virginia P. Reno. Distribution of Income Sources of Recent Retirees. Social Security Bulletin, January 1985.

Social security accounts for over half of the total income for married couples all the way through about the 45th percentile, and for unmarried men and women it contributes over half through the 60th percentile. On the other hand, pensions account for less than one-fourth of total income for most couples and unmarried persons. Pension receipt is strongly correlated with earnings. Retired workers with high social security benefits were more likely to have private pensions. Fifty-one percent of beneficiaries in the highest quartile and 42 percent of those in the third quartile had private pensions. In the bottom quartile only 3 percent received a private pension. 5/

Lastly, as would be expected, assets account for an increasingly larger percentage of total income as total income from all sources rises. At the highest income level assets are the major source of income, while at the lowest income levels all sources other than social security contribute a relatively small share of total income. 6/

Pension Coverage

The Census Bureau conducted a survey of pension coverage of persons 25 years of age and over with a wage or salary job. 7/ While over 90 percent of all civilian wage and salary workers are covered by social security, the survey showed that in 1984:

5/ Inick, Christine. Income of New Retired Workers by Social Security Benefit Levels: Findings From the New Beneficiary Survey. Social Security Bulletin. May 1985.

6/ Ibid.

7/ Pensions: Worker Coverage and Retirement Income, 1984. U.S. Department of Commerce, Bureau of the Census. Household Economic Studies, Series P-70, No. 12, September 1987.

- 52.7 million workers were covered by an employer-sponsored pension plan (i.e., they worked for a firm having a pension plan). This represents two-thirds of all wage and salary workers.
- 43.3 million workers were participating in an employer-sponsored plan. This represents 55 percent of all wage and salary workers 25 years of age or over.
- 61 percent of males were participating in a pension plan compared with 48 percent of females.
- The pension coverage rate of workers with monthly earnings of less than $500 was only 37.8 percent. In contrast, the pension coverage rate of workers with monthly earnings of $2,000 or more was 84.1 percent.
- Employees of larger firms were far more likely to be covered by an employer-sponsored pension plan than employees of smaller firms.

Amount of Income

The Census Bureau study showed that there were 11.5 million retirees receiving pension benefits in August 1984; their mean monthly pension income was $568. This included both public and private pension plans. Of all retirees receiving pension benefits, 66.4 percent were men. Their mean monthly pension income was $670, significantly higher than that for females, $366.

Three-quarters of all pension recipients, about 8.7 million retirees, also received social security payments averaging $487. The combined mean social security and pension income of retirees, including those not receiving social security benefits, was $934.

The mean monthly total household income of the 11.5 million pension recipients was $2,251. Thus, the combined amount received from social security and pension benefits, $934, represents about 41 percent of the total household income. 8/ The remainder of total household income comes from a variety of

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8/ This ratio would be understated for married couples in which both spouses had pension and/or social security benefits in their own right. This is because each recipient's benefits are compared to total household income.

sources including income received by household members other than retirees, and income received by retirees from sources other than pensions or social security benefits. The survey showed that property income was particularly important as a source of income for those who have retired.

HOW CAN WE DEFINE ADEQUATE RETIREMENT INCOME?

How much retirement income is "adequate" is a question subject to conjecture; what income is "desirable" is still another.

If one were to define adequate income as that sufficient to keep individuals above the poverty threshold, some might conclude that the retirement income system is performing relatively well. The aged were the poorest age group until 1974, when children displaced them. In 1986, the poverty rate of the aged, 12.6 percent, was more than one-third below the rate of 19.8 percent for all children. However, the aged's poverty rate was about 6 percent above the rate of 11.9 percent for nonaged adults. In order to be classified as out of poverty by the Census Bureau in 1986, an unrelated person aged 65 or over needed $5,255 in money income before taxes.

While "adequate" benefits may allow people to avoid destitution, some feel this criterion itself is wanting. Some regard a "desirable" retirement income as one that allows a degree of comfort rather than one that avoids deprivation. President Carter's Commission on Pension Policy concluded that "the replacement of preretirement disposable income from all sources [was] a desirable retirement income goal." 9/ However, maintaining preretirement living standards

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9/ Coming of Age: Toward a National Retirement Income Policy. President's Commission on Pension Policy. 1981.

does not require dollar-for-dollar replacement of preretirement gross income for most people. The Commission developed rough data which showed that gross replacement rates necessary to maintain a constant standard of living were lower for higher-income workers than for lower-income workers. After adjusting for changes in tax liability, work-related expenses, and savings and investments, the Commission estimated that in 1980 retirees needed to replace from 51 to 86 percent of before-tax final earnings, depending on income and marital status. Recent Census Bureau studies of after-tax income by age groups shed some information on the extent to which this standard is being met today. For instance, they show that elderly households tend to have lower after-tax income than younger households, but that on a per capita basis the elderly have a higher after-tax income.

Other studies, such as one done by the University of Wisconsin's Poverty Institute, point out that whether the elderly are maintaining their preretirement standard of living is not totally reflected in comparisons of direct money income. Comparisons also must take into account differences in an individual's consumption habits before and after retirement (e.g., avoiding child-rearing expenses but incurring higher medical expenses, differences in living arrangements, and differences in the availability of in-kind benefits from the Government).

Social security is designed to help provide "adequate" benefits. As was shown earlier, lower-paid workers are less likely to have savings and be covered by a pension plan. The social security program presumes they have greater need, and therefore, its benefit formula replaces a larger proportion of their preretirement income. For example, the long-term social security replacement rates--the ratio of social security benefits to final year's earnings--range from 56 percent for those who always earned the minimum wage, to 41 percent for those who earned average wages throughout their careers, down to 27 percent for those who always earned the equivalent of the social security maximum taxable wage ($45,000 in 1988).

Private pension plans are permitted to coordinate their benefit formulas with social security by essentially "picking up" where social security "leaves off." These plans, which must comply with strict Internal Revenue Service (IRS) guidelines, are said to be "integrated." Generally, a plan will not be considered discriminatory by IRS if the combined pension and social security replacement rates do not favor the higher paid. Even though integrated plans partially offset social security's weighted benefit formula and, thus, shift the distribution of pension benefits away from the lower paid, the combined pension and social security replacement rates must still favor the lower paid. A typical plan will reduce or offset the pension earned by a career employee by 50 percent of the worker's social security benefit.

Some charge that social security benefits are inadequate to live on and that companies should not be able to reduce pension benefits by a portion of the social security benefit. Others counter that without integration, lower-income workers may be "over pensioned" while higher income workers will receive "inadequate" benefits, unless the company contributes more into the plan. Thus, the interrelationship of pensions with social security goes to the heart of retirement income policy--what is adequate retirement income? What should be the role played by each component? What is the desirable retirement income mix?

Since 1943, the integration of pension plans with social security has been the subject of rules laid down by the IRS under authority of certain provisions of the Revenue Act of 1942. Pension integration guidelines were revised by the Tax Reform Act of 1986 to ensure greater equity towards lower paid workers. Some believe, however, that pension integration should be eliminated altogether.

What may be considered adequate income at the time of retirement may become "inadequate" later on. While social security benefits are presently fully indexed, inflation can significantly reduce the value of a fixed dollar pension. Although private sector plans are not required to maintain real benefit levels, surveys show that many retirees receive periodic adjustments to their pensions that on average offset about one-third of the rise in the Consumer Price Index (CPI).

Protecting pension benefits against inflation involves dealing with both preretirement inflation and postretirement inflation. When a vested employee changes jobs, the pension earned remains fixed. By the time the individual reaches retirement age, the benefits may have lost much of their value. Once benefits commence, they usually do not maintain their full value.

To a large extent our retirement income system guarantees a certain level of protection. If a worker is vested in a private-sector-defined benefit plan, benefits earned are guaranteed by the Pension Benefit Guaranty Corporation (PBGC) up to $1,909 a month (1988) in case the plan is terminated with insufficient assets. Because both social security earnings and benefits are fully indexed, present and future benefits are protected from inflation. To the extent that lower-income earners typically receive a greater proportion of their retirement income from social security, they are less vulnerable to postretirement inflation.

Moreover, effective in 1974, the Federal Government established a floor under the cash income of the aged. The Supplemental Security Income (SSI) program guarantees a needy, aged person (or a blind or disabled person) with modest liquid assets an annual income of $4,248 in 1988. About half the States pay SSI supplementary benefits to eligible individuals living independently. The combined Federal and State SSI guarantee levels for an individual living independently exceeds $5,000 in seven States.

Concern has been expressed recently about the apparent trend among companies to adopt defined contribution rather that defined benefit plans. Most pension specialists believe that defined contribution plans offer less retirement income security to long-term employees, although these plans possess certain advantages for short-term, mobile, and younger employees. Critics suggest that the rules, regulations, and complexities of the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments provide disincentives for companies to adopt defined benefit plans, and that the tax law provides incentives for companies to adopt defined contribution plans.

Defined contribution plans are coming under attack as not being "true" pension plans. They are being labeled as "capital accumulation" plans--essentially tax-sheltered savings plans. Some suggest that increased reliance on defined contribution plans as a primary source of retirement income may be undesirable for two reasons. First, employees participating in defined contribution plans bear the risk of investment performance. Second, money accumulated in their individual accounts may be used for purposes other than retirement income. Account balances are often furnished to employees in a lump sum when they leave their jobs rather than paid in a lifetime stream of retirement income. However, recent changes in the tax law serve to discourage preretirement consumption.

On the other hand, some employees and employers find defined contribution plans attractive. In addition to plan simplicity, defined contribution plans generally offer more rapid accrual of benefits and faster vesting schedules. In a sense they afford more tangible benefits because of their greater portability.

WHAT ROLE DOES FEDERAL TAX POLICY PLAY IN RETIREMENT INCOME POLICY?

Tax Treatment of Pension Contributions and Benefits

Federal income tax policy encourages saving for retirement by providing tax breaks under various qualified pension arrangements. A tax-qualified plan must follow Federal rules aimed at preventing preferential treatment of the high paid. In general, the Federal Government does not tax qualified pension benefits as income until the individual receives them. This typically reduces the individual's tax liability below what it would be if the Federal Government taxed pension benefits each year as they accrue.

Qualified pension benefits come from three sources: (1) employer contributions, (2) employee contributions, and (3) earnings on the contributions. The Federal Government excludes qualified employer contributions from employee income because it is assumed that the employer contribution is not received by the employee until the pension plan actually pays benefits to the employee. Earnings on all contributions are treated in the same manner, i.e., they are not taxed until the employee receives pension benefits. The treatment of employee contributions varies.

The Federal Government taxes some employee contributions in the same way it taxes ordinary income each year, and taxes other employee contributions as if they were not received until the employee receives pension benefits. For example, under a "salary-reduction arrangement," or so-called 401(k) plan, the employee's contributions are excluded from gross salary up to specified limits. This allows him to avoid Federal income taxes on his contribution until he receives his pension benefits. In contrast, under a "thrift or savings plan" the employee contributes funds on which he has already paid income taxes, and hence he does not pay income taxes again on his contributions when he receives his pension benefits.

The tax treatment of qualified pension benefits follows logically from the tax treatment of the contributions and earnings. In principle, if none of the contributions and earnings were taxed when earned, the pension benefits would be fully taxed when received. If some of the employee contributions were taxed, only the portion of pension benefits derived from the untaxed contributions and earnings would be taxed when received.

The tax treatment of civil service retirement benefits is the same as that of a private pension requiring after-tax employee contributions. In general, all civil service pension benefits are taxed except for a share of the pension that represents previously taxed employee contributions prorated over the life expectancy of the retiree. However, private pension plans generally do not require after-tax employee contributions unless they are made to a supplemental plan, such as a thrift or savings plan. Consequently, the full amount of private pension benefits is usually taxable.

Some private pension plans allow for the payment of benefits in a lump sum. For example, under qualified defined contribution plans, benefits might be payable in a lump sum before the normal retirement age for an employee who severs his employment. In this case, he may roll over the lump sum into an Individual Retirement Arrangement (IRA) or he may apply 5-year income averaging. These provisions can vary, however, depending on the type of plan from which the employee withdraws the lump sum.

The taxation of social security and tier I railroad retirement benefits in part reflects a complex application of pension tax treatment principles. Current law specifies the taxable portion of these benefits as the lesser of:

1. 50 percent of the taxpayer's benefits, or in other words, the assumed untaxed portion of benefits derived from the social security tax or "contribution" paid by the employer, or

2. 50 percent of the amount by which the sum of the taxpayer's adjusted gross income, tax-exempt interest income, and half of of his benefit exceeds:

   (a) $25,000, or
   (b) $32,000 for married persons filing jointly, or
   (c) zero for married persons filing separately who lived together at any time during the taxable year.

Designating half of the social security benefits as taxable above the specified thresholds allows for three concerns: (1) half of the social security tax or "contribution" is based on employee wages that are already subjected to income tax when received, (2) a judgment that only the "well off" should pay income tax on social security benefits, and (3) a need to phase in the tax instead of applying it fully at and immediately above the thresholds.

Pension Tax Expenditures

The Congressional Budget Act of 1974 (P.L. 93-344) defines tax expenditures as:

> . . . revenue losses attributable to provisions of Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of tax liability . . . .

Tax expenditures associated with pension plans come from two sources: (1) when taxes are deferred on accrued pension benefits until employees receive them, the present value of the tax revenue eventually collected is less than if it were collected each year on the contributions and earnings; and (2) when a retiree receives his pension benefit, he may be in a lower income tax bracket than he was in while working.

Table 1 provides the estimates of tax expenditures on pensions in the President's FY89 budget. The estimate for private pensions alone was $58.7 billion, while social security and IRAs each had associated tax expenditures of $13.5 billion and $12 billion, respectively. No total is shown because these estimates are not additive. Also, they are not estimates of the amount the Federal Government would collect if the tax expenditures were repealed because: (1) a change would have secondary effects as individuals shifted their funds to other tax-favored activities, and (2) a change could affect various aspects of economic activity, such as consumption, saving, investment, and economic growth.

Tax expenditures associated with pensions have the goal of promoting additional saving toward retirement. Various reviews of the evidence conclude that the favorable tax treatment of qualified pension plans has increased savings, but by less than a dollar for each dollar of pension contributions. In other words, some saving for retirement purposes in pensions was transferred from other saving arrangements. The effect of the IRAs on savings is even less clear.

TABLE 1. Revenue Loss Estimates for Tax Expenditures on Pensions for FY89 ($ in billions)

Pension	Revenue loss
Social Security (OASI)	$13.5
Railroad Retirement	0.4
Net exclusion of pension contributions and earnings:	
Employer plans	58.7
Individual Retirement Accounts	12.0
Keoghs	1.5

Source: Executive Office of the President, Office of Management and Budget. Special Analyses, Budget of the United States Government, Fiscal Year 1989. p. G-39.

Critics of the favorable tax treatment of qualified pensions have argued that the distribution of pension tax expenditures by income class is regressive, i.e., higher income individuals benefit proportionately more than low-income persons. This is true for any generally available deduction or exclusion from taxable income in a progressive tax schedule because a dollar of deduction or exclusion is more valuable to a person in a high tax bracket than to a person in a low tax bracket. In other words, the deduction or exclusion reduces a high-income person's taxes proportionately more than a low-income person's taxes because the high-income person faces a higher "marginal tax rate." Opponents of this view argue that this necessarily follows from the nature of a generally available exclusion from taxable income in a progressive income tax schedule. Instead, they argue that the tax expenditure is distributed fairly because it is roughly proportional to taxes paid.

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PART 1. RETIREMENT INCOME FOR AN AGING POPULATION: AN OVERVIEW

I. INTRODUCTION

A. PURPOSE

The average age of the U.S. population will increase by 24 percent and the number of elderly will grow by 53 percent during the next 30 years. Steadily declining birth rates and increasing longevity underlie this long-term demographic shift, which is common to all developed societies. In addition, the baby-boom, baby-bust cycle of the post-war decades highlights issues faced by countries as they move to a higher ratio of aged to nonaged.

Concern has arisen about the effect of population aging on the Nation's capacity to support its retirees while meeting other national goals. To help it consider the advisability of actions to ease the transition to an older society, the Committee on Ways and Means asked the Congressional Research Service (CRS), with support from the Congressional Budget Office (CBO), to develop an analytic framework for understanding the implications of the aging of the population and the baby boom's retirement for Federal programs and policies. Specifically, the Committee asked for a report that would: (1) provide a baseline of common data and issue definition, (2) assess the goals of the retirement income system, (3) measure economic status and income adequacy, (4) describe the set of programs and policies that make up our current system, and (5) analyze future issues. The Committee noted that, so far as possible, it intends to take account of the implications of this demographic shift as it considers proposals for future policy and program changes.

This report responds to the Committee's request by providing this overview of the subject, and a series of background papers.

B. BUILDING BLOCKS FOR AN ANALYTIC FRAMEWORK

Analytic frameworks consist of data and analysis, organized around central concepts with an organizational structure that integrates them. This overview, and the background papers that follow, constitute such an analytic framework. The overview draws heavily on the background papers and on discussions about them held periodically during the past year by a team of analysts from CRS and CBO.

As the study proceeded, general understandings were reached on important concepts that structured the dialogue, undergirded much of the analysis, and focused many of the conclusions. These concepts are implicit throughout the report—in both the overview and the background papers. They are made explicit here because of their significance to the study. These basic concepts include how claims for retirement income are created, the role of economic growth, the limitations of projected data, the way economic and government institutions respond to changing conditions, and some approaches to defining dependency and burden as these terms are used in discussions about the aging of the population and the retirement of the baby boom.

1. Building Retirement Income Claims

The foundation of the report's analytic framework is the idea that during a person's lifetime of work, by virtue of this work and through saving, various private and public retirement income claims are created. Retirees, who no longer have income claims based on their current work, can begin to draw on their accumulated claims for retirement income. (These work-related claims are supplemented by legislatively established minimums that provide income to individuals who reach old age without sufficient claims based on prior work.)

Although retirement income claims build up over a work career, their future value can only be projected based on assumptions. The rate of economic growth during the working life, notoriously unpredictable, will largely determine the value of these claims. If moderate growth rates (the so-called II-B assumptions from Social Security's Board of Trustees)[1] persist over the next quarter century, most of the elderly (and also the nonelderly) will have real income far in excess of current levels. On the other hand, slow or no economic growth is a recipe for social strain—and not just over retirement income.

2. The Role of Economic Growth

The report highlights the role of economic growth. In the first place, even moderate rates of economic growth, if consistent, over a 25-year period will substantially raise standards of living and increase national wealth. For example, assuming the rate of economic growth in the Social Security intermediate projections, average annual wages (in real dollars) will increase by 35 percent over the next quarter of a century from $18,135 at present to $24,546 in 2010. It seems plausible that accumulated claims for retirement income (from social security, pensions, or financial assets) will more likely be honored in full if society's overall wealth is steadily increasing.[2]

The value of claims for retirement income from a variety of sources is determined in large part by economic growth. For example, using Social Security's intermediate assumptions, the value of a social security retirement benefit (in real terms) in 2010 is projected to be substantially greater than today, largely because of the effect of real growth on wages. The value of private pension claims also is tied to the real economic growth. Although there are few long-run projections of income from all sources for future retirees, those currently available assume positive rates of economic growth and accordingly show robust increases in real retirement incomes. If these assumptions are incorrect and favorable growth rates do not materialize, future levels of retirement income will be correspondingly less.

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[1] Annual reports from the Board of Trustees of the Social Security system project social security expenditures, revenues, and trust fund solvency for 75 years in the future. The Trustees present four different projections that differ because of relative "optimism" or "pessimism" regarding their economic and demographic assumptions. Alternative I is based on the Trustees' optimistic assumptions and Alternative III the pessimistic assumptions. Alternative II-B is an "intermediate" projection and is the one most often used to describe the system's actuarial balance. Most data in this report are based on the II-B assumptions. They will simply be referred to as intermediate projections.

[2] Economic growth is important, and the report highlights it. However, it should not be seen as a panacea and its effect should not be exaggerated. For example, if real wage growth averaged 2.5 percent per year, an average not sustained since the 1950s, rather than the 1.5 percent assumed in Social Security's intermediate projections, the cost of social security as a percent of taxable payroll over the next 75 years would only be 11 percent less. See section VI of the overview and chapter 8 of the background papers for a more comprehensive discussion of this point.

The report emphasizes the widely accepted link between increased savings, increased investment and growth. Thus, increasing saving (thereby reducing consumption) over the next 25 years should increase national wealth. The increased saving would support greater investment in private and public capital (both physical and human) and in domestic and foreign enterprises. Fiscal policies to reduce consumption, especially those that reduce the Federal deficit, are the most likely to raise the national saving rate (above what would otherwise have occurred). As discussed in section III and in chapter 4 of the background papers, policies to pre-fund retirement income claims would increase national savings, but only to the extent that the new savings were not offset elsewhere in the economy. Currently, the large Federal budget deficit is reducing national saving, and international borrowing is increasing our future obligations for repayment. Both will likely add to the challenge of financing the baby boom's retirement income claims.

3. Analysis Using Statistical Projections

Policy analysis implies assessment of the future and often relies on relevant statistical projections. Projections of future demographic and economic conditions may be grounded in empirical facts and research, but they are driven into the future by assumptions that are sensitive to changes in complex behavioral relationships. As rigorous as the projections may be, they remain merely projections, and the farther into the future, the more variable the effects of the assumptions and the more speculative the projections become. To illustrate, concerns about the effects of the baby boom's retirement should be tempered by noting that the oldest baby-boom cohorts do not reach age 65 for nearly another quarter of a century.

Nonetheless, analysis of program and policy issues in the future is required, and objective projections do facilitate policy debate. For statistical data on future economic and demographic conditions, this report relies on standard projections by the Bureau of the Census and the Department of Health and Human Services (HHS). However, the report does not focus on the projected data, but uses them as a backdrop that can prompt analytic insights.

4. Incremental Public and Private Response to Changing Incentives

Democratic and market institutions are designed to be flexible in their response to changing and unanticipated conditions. The capacity for flexible response is important, not only because projections so often miss the mark, but modifications in current programs and policies may be called for as the future unfolds. If the institutions work smoothly, required responses to future problems identified with the aging of the population and the retirement of the baby boom will be identified systematically and debated as the issues arise. The levels of productivity and consumption, investment and saving, and work or retirement will change as economic circumstances evolve. Similarly, governmental policies about the distribution and adequacy of income and program benefits, of incentives and regulation, will be modified incrementally as conditions warrant.

This is not to say that Congress should be unconcerned about possible means for preparing for the future and the need to accommodate an aging population. On the contrary, this report creates a framework to understand the relationship between current issues and long-run conditions. The resolution of current issues unavoidably has future effects and policymakers try to anticipate them.

5. Dependency and Burden

Dependency and burden, often not rigorously defined, are used in discussions about retirement income policies and programs. This report uses these terms, but attempts to define them and point out their weaknesses and strengths in understanding the implications of the aging of the population and the retirement of the baby boom.

a. Dependency.—Section II of the overview and chapter 3 of the background papers analyze commonly used measures of dependency. These analyses conclude that use of these measures raises serious definitional and methodological issues. For one thing, analyses based upon measures of dependency imply that only the working groups of the population have primary claims on the production of the economy, and that groups not currently in the workforce are "dependent" on the workers. This type of analysis runs the risk of overlooking the legitimacy of the claims built up by retired groups who through their lifetime of work and saving contributed, along with previous generations, to the capital base that provides income to working and retired people alike. The productivity of the working groups is, in part, a function of this capital base, including physical capital and human capital. This overall capital base is built partly by the work and saving of previous generations, and, in conjunction with the labor of the current workforce, accounts for the economy's productivity.

Dependency measured simply as the ratio between workers and retirees has been used to measure the nature of the problem of the baby boom's retirement, but this simple ratio overlooks the potential of improving economic productivity by a shift from labor to capital should that become necessary.

b. Burden.—This report offers no definitive account of any "burden" that might result strictly from the demographic shift. Regardless of the legitimacy of retirement claims built up over a lifetime of work and regardless of the intervening growth of the economy, all demographic signs point to a major increase, taking place between approximately 2010 and 2035, in the proportion of the population that is elderly. When that shift occurs, the share of the Nation's productive capacity needed to provide income for the elderly will increase substantially. In that sense it will constitute a "strain" or a "burden" on the economy.

Sections IV and VI of this overview and chapter 8 of the background papers discuss projections of this demographic shift and present measures of its effects. Each year, the Social Security Board of Trustees projects the financial condition of the Social Security programs. These projections show, based on current law, what the cost of the Social Security programs will be in future years as a percent of total "covered payroll" (the proportion of national income upon which payroll taxes are levied), and as a percent of the gross national product (GNP). Using the GNP measure, for example, social security payments as a percent of GNP will rise from 4.44 percent at the beginning of the baby boom's retirement (roughly 2010) to 6.51 percent at the end (roughly 2035)—an increase of 47 percent over a 25-year period. (The cost as a portion of covered payroll shows an increase of 62 percent.)

This demographic fact of life cannot be avoided. However, this report makes the following points:

—The baby boom has "strained" the Nation's governmental and private institutions since its beginning 40 years ago, from hospital pediatric wards, to schools, to the workplace. So far the institutions and the economy have adjusted. If, in the year 2010, the economy is suffering severe dislocations, they may be caused by other serious problems, rather than from the elderly status of the baby boom's oldest cohort. After all, the entire baby boom does not become elderly all at once, but over two decades.

—If, as the baby boom's retirement approaches, and while it is going on, Congress identifies changes that are needed in retirement income policies and programs, it has a number of options that can be put in place as their need becomes more clearly seen. (Section VI and chapters 8 and 9 of the background papers discuss some of these.)

—To some extent baby-boom retirement problems are self-adjusting. If the economy grows more slowly than the intermediate projections, the value of built-up retirement claims will automatically be less. Furthermore, as pointed out in section V below and in chapter 6 of the background papers, recent trends to younger retirement ages seem sensitive to levels of retirement income. From 1967 to 1984, the earnings of the elderly dropped significantly as a source of their income, replaced by income from financial assets. Substantially lower retirement income claims may lead to a return to greater earnings among the elderly.

—The effectiveness of ameliorating any future "burden" on the economy by actions taken now to reduce the rate at which these retirement income claims build up, or actually to reduce them to current retirees, is questionable. Proposals to reduce social security benefits of nonpoor beneficiaries, for example, could be defended on the grounds of more equitable treatment of today's retirees vis-a-vis today's workers, many of whom have suffered a reduction in real earnings. But reductions in today's social security benefits would ease the transition to the higher cost rate required between 2010 and 2035 only if such reductions led to increased national savings and these savings to increased investment and growth. Furthermore, reductions in today's benefits would bring about a further increase in Social Security's trust fund buildup, which raises issues of its own as discussed in section VI below and in chapter 8 of the background papers.

—This report does not focus on the meaning or measurement of the term "intergenerational equity." Instead, the report develops other measures and concepts that are thought to be more useful in understanding the implications of the aging of the population and the retirement of the baby boom.

C. SUMMARY

The structure and content of the overview and the background papers provide a graphic representation of the report's analytic framework. Following its introduction, this overview is divided into six parts:

Demography: The Backdrop

Understanding and defining issues of population aging and baby-boom retirement requires, first of all, an appreciation of demographic data. Statistics about population growth and characteristics are used to assess past trends and future projections. Section II reviews historical demographic trends that have led to the steady aging of the population in this century and considers major effects of the baby boom, an aberration in long-term trends, on the demographic characteristics of the population. This demographic perspective sets the stage for consideration of future retirement income policies.

The projections depend importantly on assumptions about birth rates, mortality improvements, and immigration policy. If mortality assumptions used by the actuaries who estimate the number of beneficiaries of various public programs in the future underestimate longevity, unanticipated increases in the elderly would strain not only the cash income support systems, but probably the medical care systems as well because the elderly, particularly those over age 85, are heavy users of medical care services. This strain may be offset somewhat because retirement income claims generally are not increased after benefits begin to take account of economic growth. In fact, some of these claims do not even keep pace with inflation after retirement.

Demographers have developed the concept of dependency ratios, referring to the relationship between the number over age 65 and those age 20–64 (the working-age population). Section II shows this to be an inadequate measure of dependency because it does not take into account the flexibility of the economy and the capacity of potential workers of any age to adapt to changing conditions. Conclusions about the effect of the baby boom's retirement on the economy drawn solely from simple dependency rate analysis may be misleading.

Preparing for the Retirement of the Baby Boom: Saving and Investing

The economic imperative is as important to the future of retirement income policy as the demographic imperative—and more difficult to project. Section III of the overview discusses the impact of saving and economic growth on the baby boom's future retirement income.

The uncertainties in projecting changes in population pale beside difficulties in projecting future economic performance—especially for periods far in the future. (The oldest members of the baby boom will not reach 65 until 2010, nearly a quarter of a century from now.)

Improvements in retirement income during the past 40 years attest to the importance of economic growth. Relatively high levels of retirement income enjoyed by many of today's retirees were produced by the relatively rapid real wage growth during the working years of today's retirees. Anemic real wage growth during the 1970s and so far into the 1980s, years when many of the baby boom began their work careers, will, if continued into the future, slow the growth of retirement income and make harder the task of providing their income in retirement.

Federal Policies and Roles in Retirement Income

Federal retirement income policies and programs appeared and developed in the 20th century. Debates over the need for pensions and social insurance began before the turn of the century, but only in the 1920s were teachers, Federal employees, and some private sector employees covered by pensions. Still later, in the midst of the Great Depression in 1935, social security established a floor upon which additional sources of retirement income could build. Three decades after that, the Congress enacted health insurance for the elderly; in 1974 it passed legislation to broaden Federal regulation of private pensions.

Over the past 50 years, Federal retirement income programs have matured, Federal policies have evolved, and Federal expenditure levels have grown. Federal policies have dominated retirement income provisions and their effects are seen in the Federal budget, both as direct expenditures and as tax subsidies. The growth and projected future size of these expenditures and subsidies are large in dollar terms and as a percent of the budget. When viewed as a percent of the GNP, however, they seem more manageable. For example, social security expenditures as a percent of GNP have increased from 2.52 percent in 1965 to 4.79 percent in 1984. If the intermediate demographic and economic assumptions of Social Security's Board of Trustees hold true, social security payments will rise to 6.51 percent of the GNP by the year 2035, the peak of the baby boom's retirement.

Federal policies for retirement income programs have evolved during this century. These policies, which have influenced program structure and legislative debates, derive from goals for providing retirement income that ranges from that sufficient to provide (1) a minimum level of benefits, to (2) a standard of living after retirement that is roughly consistent with the standard of living while working.

In carrying out these policies, two principles of cost and risk influence policy decisions: (1) lower-income retirees receive relatively higher benefits compared to their income while working than do higher-income retirees, and (2) the Federal Government ensures, to the extent possible, that claims for retirement income are honored.

Influence of Income on Retirement Patterns

In recent years older Americans have been financially better off than ever before and have been retiring at younger ages, a trend that raises questions about the potential size of the nonworking, retired population when the baby boom approaches their 60s. Section V reviews the economic status of the elderly, the income sources and amounts available to today's retirees, and addresses the prospects for the baby boom's economic status in retirement.

Early retirement became feasible for today's elderly because of rapid growth in social security and other employment-related retirement income. Strong economic growth from the end of World War II until the mid-1970s established the foundation for these benefit increases and also permitted today's retirees to build up substantial levels of other financial assets.

In contrast to today's retirees, the baby boom, since its entry into the labor force in the early 1970s, has seen much lower and more sporadic real wage growth. Unless current projections (for example, in Social Security's intermediate assumptions) for a return to sustained favorable economic conditions are borne out, today's young workers may approach retirement in a relatively less favorable position than their retired parents. One way to offset this bleaker retirement outlook, should it materialize, would be for the baby boom to reverse a 40-year trend by delaying retirement and working longer.

Building Claims for Retirement Income

Retirement income consists of claims, accumulated during working careers, which are then redeemed against the economy in retirement. Section VI examines how those claims are created and enforced in both the public and private sectors. If the economy grows at the rates of the intermediate Social Security assumptions, projections of social security and private retirement income sources indicate that most of today's workers will have a standard of living in retirement that approaches pre-retirement levels and is substantially higher than that of today's retirees.

Social security is, and is projected to remain, the largest source of retirement income, and it constitutes the largest domestic commitment of the Federal Government. Consequently, its long-term funding dominates discussions of the baby boom's retirement. Current policy commits the Federal Government to funding the baby boom's social security benefits in a way that, at the least, will affect the Nation's tax structure over the indefinite future. In addition, if social security trust fund surpluses are built up in the context of a relatively tight overall fiscal policy, they could significantly affect national savings.

Despite concerns about funding methods, the fiscal implications of either current funding policy or its alternatives may be largely independent of the particular mechanisms. Accordingly, it also is important to consider projections of social security as a share of the total economy. Compared to GNP, the program's projected increase is within the range of change that the Nation has previously accommodated, both in the size of the overall Federal budget and shifts in its major components. Issues concerning the distribution of benefits in social security have emerged in the past and can be expected to in the future. These benefits distribution issues, which may be raised independently of the baby boom's retirement, are likely to figure into debates of how to accommodate the increased costs of that retirement.

Private retirement claims involve Federal tax policy, Federal guarantees, and fair dealing in the labor market. The baby boom's private retirement claims are subject to many uncertainties. Some of these uncertainties relate to underlying economic conditions, others to various risks that all workers, whether in the baby boom cohorts or not, encounter in accumulating private retirement claims. In particular, investment risks, inflation, employer choices, and job mobility (particularly in an inflationary environment) can affect individual outcomes. As a result of these factors, payments from pensions and similar plans are concentrated among higher-income workers; however, the degree to which those payments represent additional retirement or national savings remains unclear. Also, the tax advantages of qualified plans are more valuable to some workers than others, a matter which increasingly has occasioned debates over tax equity. Finally, future choices about retirement policy increasingly will affect, and be affected by, the economic choices the United States will be facing as its economy becomes more interdependent with the global economy.

Aging, Health, and Medical Care

Payment for medical care may be an exception to the conclusion above about the future capacity to maintain living standards. Section VII considers this issue. Rapid increases in the cost of medical care during the past two decades, and prospects for continuing increases—along with continuing concerns about gaps in medical care coverage—have created major policy issues that the Congress currently is considering. In fact, medical care issues, including some that directly affect the elderly, could be on the congressional agenda indefinitely. For example, at this writing, the House has passed and the Senate Committee on Finance has reported out legislation that would place a ceiling on elderly out-of-pocket expenditures for hospital care. However, this legislation does not include provision of long-term home and nursing home care required by many of the elderly who, as they age, suffer from chronic ailments that often worsen and for which cure seldom is possible. With ever-increasing numbers of the elderly age 85 and older, providing insurance for this kind of medical care (not now covered by medicare) will stimulate legislative attention.

If expenditures for medical care continue to increase faster than the economy grows, the ability of the elderly (whose overall incomes often do not keep pace even with inflation, let alone economic growth) will be more vulnerable to medical care expenditures not covered by medicare. Furthermore, continued cost escalation would inevitably drive medicare's hospital insurance trust fund into long-run imbalance. Trust fund balances would expire in the year 2002 according to the most recent estimates of Medicare's Board of Trustees. These increasing costs will be driven by continued growth in the volume of treatment. To hold down on costs, it may be necessary to regulate increases in treatment volume, a very controversial solution.

II. DEMOGRAPHY: THE BACKDROP

Despite variations in projections caused by different assumptions, all population projections point to the aging of the U.S. population. This general conclusion provides an important reason to examine current policies. At the same time, spelling out the demographic profile that leads to that conclusion will create a context within which those policies can be examined. As time passes, and more demographic knowledge is gained, the projections will be altered along with the profiles that follow from them. Policies, too, will be evaluated and modifications to them debated. This section examines how current policies might be affected by the everchanging demographic context in which they operate.[3]

A. THE AGING OF AMERICA

1. The Baby-Boom "Bulge" in a Long-Term Trend

The baby boom of the mid-1940s to mid-1960s will lead to more elderly in the second and third decades after the turn of the century. Yet, the aging of the baby-boom is part of a longer term aging trend that can be traced back well before the high birth rates of the baby boom; this longer trend was partially disguised when the boom was in the younger years of its life cycle.

The size of the elderly population—all persons 65 and over—has increased and will continue to do so. From the beginning of this century until 1980, the elderly population has grown at a rate nearly twice as fast as the total population. Over the next several decades the growth will continue at a rapid pace, as the elderly population more than doubles between 1980 and 2020. The size of the very old population (persons 85 and over) will grow even faster, and the rate of growth will accelerate as the baby boom reaches that age. Between 1980 and 2020, an estimated 4.9 million very old persons will be added to the population, but between 2020 and 2060, as the baby boom becomes very old, 8.3 million will be added. (See figure 1.)

It is important to put this increase in the number of elderly in an historical perspective. The anticipated growth of the elderly population, while rapid, is not unprecedented. In 1980, the elderly population was nearly four times as large as it was 50 years earlier. In comparison, the elderly population in 2030 is expected to be 2.5 times as large as in 1980.

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[3] Chapter 2 of the background papers sets forth a detailed analysis of demographic projections and trends. This part of the overview draws on that analysis.

IV. Federal Policies and Roles in Retirement Income

A. HISTORICAL CONTEXT

The United States and other modern societies have developed structured means for workers to accumulate claims against economic resources that can be drawn upon during retirement years. Over the past century changes in industrial organization, job mobility, and greatly improved life expectancies led to political support for new Federal retirement income policies. Pressures for Federal policies started in the early 1900s, and accelerated in the 1930s and 1940s. At present, the Federal Government exercises paramount responsibility for the Nation's organized systems of retirement income provision—primarily through social security, the tax subsidies afforded pensions and other forms of retirement plans, and the broad regulatory framework and guarantees of the Employee Retirement Income Security Act. Earnings-related social security and pension claims are supplemented by a means tested Supplemental Security Income (SSI) program that established a minimum income floor for all people age 65 and over. (SSI, enacted in 1972, consolidated public assistance programs for the aged, blind, and disabled, and placed a Federal floor under the benefits.) Since 1965, the Federal Government's Medicare and Medicaid programs have increased the elderly's access to medical care and have helped preserve their income and assets in the face of deteriorating health. And, finally, the Federal Government has fostered, through tax advantages and Government guarantees, the widespread accumulation of personal wealth in housing, historically a key asset in retirement years. These various Federal programs, tax preferences and guarantees enable workers to acquire larger and more secure retirement incomes earned over a lifetime of work.

B. FEDERAL POLICIES

1. Policy Objectives

Two retirement income objectives influence national policy: (1) that all elderly persons have a minimally adequate income, and (2) that workers, over their working careers, be able to accumulate income claims sufficient to maintain an appropriate relationship to pre-retirement living standards after they retire.[16]

a. Minimum adequacy objective.—The clearest policy objective calls for a minimally adequate living standard after a particular age—65 under current policy. This objective is directed at elderly persons who most often have had sporadic attachment to the workforce or who worked at very low-paying jobs. Most households whose principal earner had a strong attachment to the workforce will have built up sufficient claims for earnings-related retirement income to meet any minimum standard of adequacy.

However, the income replacement objective by itself would not prevent low-wage workers from falling below minimum adequacy (as measured by the poverty level, for example) when they retire. Social security helps prevent this for low-wage earners by "tilting" its benefit formula in their favor. Recent changes in the rules governing tax-qualified pension plans have been directed to similar ends by further limiting the amount that pension benefits can be reduced by, for example, the amount of social security benefits received. As a back-up for all aged individuals, including those who had little attachment to the labor force, a number of income-tested programs exist—particularly the SSI program, veterans' pensions, and food stamps.

Federal policies and programs have succeeded in achieving minimum income adequacy standards for most of the elderly. According to the most commonly accepted measures of minimum adequacy—the poverty and near-poverty levels—average income of the elderly today compares favorably to that of the nonaged. And fewer of today's elderly suffer from poverty than their counterparts in the 1950s and 1960s.

Although incomes of most elderly married couples meet national income adequacy objectives, the circumstances of single elderly persons (particularly if they are very old) often remain marginal. Many elderly singles have sufficient income to pay for most basic living expenses, but they have limited ability to weather financial dislocations, such as a major uninsured illness. In addition, many of the elderly who are not poor nonetheless have incomes sufficiently low that they are only slightly above the poverty threshold.

Projections of the retirement income of today's workers indicate that, if real wages grow in the future at the rate assumed by Social Security's intermediate assumptions, when these workers retire their economic status will exceed that of today's elderly. But even assuming these moderate rates of economic growth, poverty may remain a substantial problem for many elderly singles.

The improved economic status of the elderly testifies to the powerful effects that the maturation and increased benefit levels of social security and pension plans have had. General economic growth made these benefit improvements possible, and also enabled most of the elderly to acquire income producing financial assets. In fact, income from financial assets grew most rapidly as a source of retirement income from 1967 to 1984. The combination of Federal policies and general economic growth improved the financial conditions of most elderly to levels unprecedented in the Nation's history. At the same time, these policies and this prosperity—in particular, the return on financial assets—drove elderly poverty rates from levels far above the rest of the population to levels below the overall average. Thus, in 1986, 12.4 percent of aged persons were poor, compared to 13.6 percent of all persons and 19.8 percent of children.

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[16] In 1981, President Carter's Commission on Pension Policy recommended sufficient retirement income to maintain pre-retirement standards of living as a national objective. This proposal has never been formally adopted (nor rejected) but it does, in some instances, serve as a policy guide.

b. Replacement of pre-retirement living standards.—Retirement income programs, supported by Federal policies and economic growth, have enabled most recent retirees who had a strong attachment to the workforce to acquire retirement income claims sufficient to maintain a standard of living roughly comparable to the one they had while working. Social security carries the major weight in achieving this objective for workers in the lower and middle portion of the earnings distribution. But social security, by itself, does not meet this standard for middle- and upper-income earners. For these workers, Federal policy builds upon their social security by providing tax advantages for their pensions and other tax-favored plans. Tax preferences for owner-occupied housing also are more favorable to higher-income workers. In addition, many higher-income retirees receive income from financial assets which, while the income is taxable, the assets themselves are often guaranteed by Federal insurance agencies.

The income replacement objective usually is framed as a ratio of post-retirement to pre-retirement income. Use of these ratios implicitly assumes that an individual's or couple's post-retirement consumption should equal pre-retirement consumption of housing, clothing, food, entertainment and such. Taxes, work expenses, the need for savings after retirement, and other living expenses are smaller than before retirement, and the consumption target can be met with an income replacement ratio of less than 1.0. Using income just before retirement as the denominator in the calculation of target replacement rates, income replacement ratios that maintain consumption have been estimated to range from about four-fifths for those at the very bottom of the earnings distribution to around two-thirds for median or higher earners.[17] This point is discussed further in section V of the overview.

During the past 20 years, economic characteristics of the elderly and the nonelderly have increasingly grown to resemble one another. For most, pre-retirement standards of living are being maintained during retirement—at least during an individual's or couple's 60s and early 70s. However, the cumulative effects of inflation, diminished assets, and increased health costs may cause living standards among older retirees, especially widows, to fall. And people who were poor during their working years can expect to live in poverty or near-poverty in old age.

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[17] Boskin, Michael, and John Shoven. Concepts and Measures of Earnings Replacement During Retirement. National Bureau of Economic Research. Working Paper No. 1360N. June 1984. (Hereafter cited as Concepts of Earnings Replacement)

2. Allocating Costs and Risks

Two principles of cost and risk allocation generally have influenced Federal policy and program objectives. These principles—both of which would be abandoned by some proposals for basic restructuring of the current retirement income system—cause higher-income workers to pay for some of the benefit costs of lower-income workers. They also spread out the risks that workers face while accumulating retirement claims and ensure that these claims are honored in retirement.

a. Allocating the costs of retirement income.—Long-standing policy supports the premise that higher-wage workers should bear the larger proportion of retirement costs. Social security clearly recognizes this policy by paying benefits to lower-wage workers that are relatively high in proportion to their earnings. These high benefits for low-income workers are paid for by higher-income workers who pay disproportionately high payroll taxes relative to the benefits they receive. The so-called "tilt" in the social security replacement rate formula redistributes benefits from higher to lower earners.

In pensions and other tax-favored plans, the redistribution of costs and benefits is less evident and certain. For example, the so-called "integration" provisions in the tax code are intended to limit the extent to which such plans may counter the effects of the social security tilt. The overall impact of these and other rules for pensions is difficult to assess.[18]

b. Minimizing risks.—The Nation, through Federal Government programs, collectively insures against some risks in retirement income. In particular, future social security benefits depend directly on the ability of the Federal Government to satisfy the statutory claims that workers have accumulated. Further, many private retirement portfolios (company pensions and individual savings) are invested partly in Treasury obligations which carry both a Federal statutory and contractual commitment. In addition, the Federal Government exercises broad regulatory supervision of most private investment markets, and has created various insurance systems—for example, the Federal Deposit Insurance Corporation (FDIC) and the Federal Savings and Loan Insurance Corporation (FSLIC)—that guarantee deposits in most banking and thrift institutions.

Furthermore, workers acquire claims on future economic productivity through the accumulation of contractual and other legal rights that ultimately depend on the viability of private sector businesses and investments. Unanticipated economic dislocations could invalidate such retirement income claims. Workers' expectations about their benefits from tax-favored pension plans are also often conditional on the future decisions of their employers, which too are affected by economic circumstances. Even social security and retirement claims held as Government bonds ultimately depend on the long-run overall viability of the Nation's economy.

Federal legislation minimizes risks in private pension retirement claims. In particular, the Employee Retirement Income Security

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[18] For a more extensive discussion of how pension costs may be shifted from lower- to higher-income workers, see CBO, Tax Policy for Pensions, chapters IV and V.

Act of 1974 (ERISA) imposes a variety of requirements on retirement plans. Some requirements govern the terms and conditions of participation, coverage and vesting. Others impose portfolio diversification and fiduciary standards on plan sponsors, including a requirement that prevents most pension plans from holding more than 10 percent of its assets in the stock or property of the sponsoring employer. In addition, the Pension Benefit Guaranty Corporation (PBGC) guarantees accrued benefits (up to certain levels) in those defined benefit plans that terminate with insufficient assets to meet pension obligations.

The congressional debate continues about the Federal Government's role in further circumscribing the risks associated with retirement income claims. Congress has considered, but not adopted, additional Federal Government regulation that would insure retirement income claims against risks of portfolio concentration, default, and unanticipated inflation. The recent experience of pension terminations and asset reversions has brought into focus some fundamental questions about what are legitimate expectations of workers in their defined benefit pension plans. ERISA has safeguarded worker coverage and vesting in pension plans, but this law has paid comparatively little attention to the value of the benefits—especially as those values are eroded by the combination of job changing and inflation.

C. THE FEDERAL FINANCIAL ROLE IN RETIREMENT INCOME POLICIES

Federal retirement income policies are carried out by (1) direct spending programs, such as Social Security; (2) tax subsidies, for qualified private pensions and other plans; and (3) Government-sponsored insurance, such as the PBGC.

1. Direct Federal Spending on the Elderly [19]

This section analyzes trends in Federal spending on the elderly during the past 20 years and compares it to projected spending during the period in which the baby boom will be retiring. The effects of Federal spending on the elderly in the different years is measured by comparing this spending to the GNP.

a. Recent trends in Federal spending on the elderly.—The amount of Federal resources spent on the elderly (generally, those aged at least 65) grew rapidly over the past 20 years because of maturity of the programs, rapid economic growth, growth in the size of the elderly population, and decisions to cover an increasing share of their needs through public programs. Between fiscal year 1965 and fiscal year 1985, Federal spending for the elderly—on cash and noncash transfers, Federal retirement, and disability benefits and services—grew from about $63 billion to nearly $260 billion in constant 1985 dollars, or from about $3,400 per elderly person to more than $9,000 in constant dollars. During that period, spending for the elderly rose from 16 percent of 27 percent of all Federal outlays, or from about one-third to nearly one-half of all outlays for domestic programs (that is, spending other than for defense and net interest payments). In this 20-year period Federal spending for the elderly grew from 2.8 percent to 6.6 percent of the GNP.

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[19] This analysis borrows heavily from a statement by Rudolph G. Penner, Director, U.S. Congressional Budget Office, delivered before the Subcommittee on Economic Resources and Competitiveness, Joint Economic Committee, July 31, 1986.

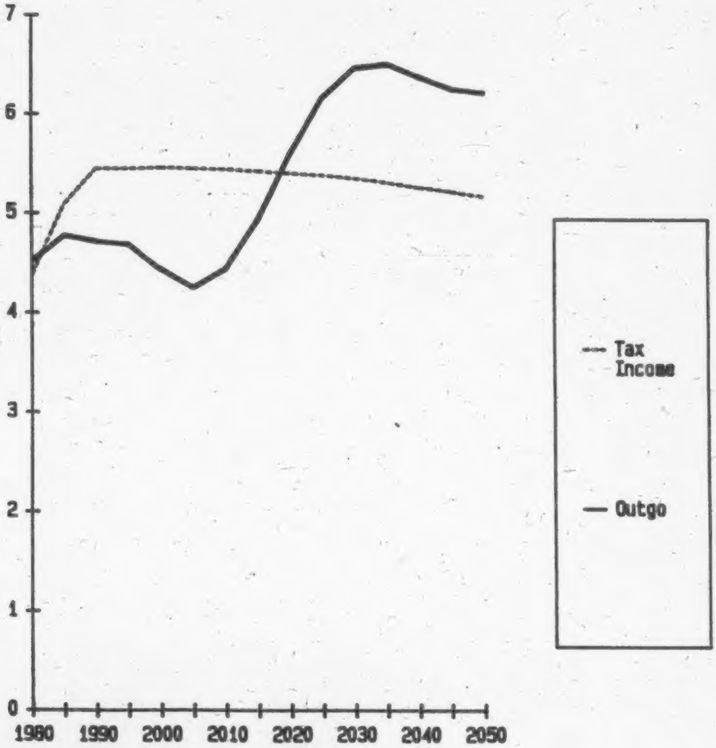
b. Projections of future Federal spending on the elderly.—Future Federal spending on the elderly will depend on rates of economic growth and on future public policy decisions. Although precise budgetary impacts cannot be forecast, it is possible to identify in broad terms how demographic trends would affect major categories of Federal spending if current policies are essentially unchanged.

These projections should be treated with caution, for they are sensitive to the assumptions on which they are based. For example, under the Social Security Trustees' most optimistic assumptions, social security cash outlays are expected to amount to 5.32 percent of GNP in 2035. By contrast, under the most pessimistic assumptions, social security cash outlays would be 8.33 percent of GNP. Furthermore, the projections assume a continuation in the Nation's willingness to spend an ever greater fraction of its resources on medical care, for reasons that are largely independent of the aging of the population.

Social Security.—Projections based on Social Security's intermediate economic and demographic assumptions show social security expenditures rising to a peak of 6.51 percent of GNP by 2035, in the midst of the baby boom's retirement. This represents an increase of 38 percent over the current level of 4.73 percent. This percentage actually declines over the next 20 years, before the baby-boom retirement begins, reflecting the low birth rates of the 1930s. (Figure 2 projects these trends through the year 2050 and compares social security expenditures to tax revenues—both as a percent of GNP.)

Figure 2.
Social Security Trust Fund
Income and Outgo

As a Percent of GNP



Source: Social Security Administration. Long Range Estimates of Social Security Trust Fund Operations. Actuarial Note 130. April 1987.

Medicare.—Growth in the number of elderly people could affect rates of increase in Federal spending for elderly medical expenditures more significantly than it does social security (see section VII and chapter 10 of the background papers for a more complete discussion of this point). Currently, medicare pays for about 49 percent of total costs of providing acute health care for older Americans.[20]

In contrast to social security, projection of medicare outlays assume continued medical care expenditure growth in excess of GNP growth. The Hospital Insurance (HI) component of medicare is projected to rise from about 1.16 percent of GNP in 1987 to about 2.86 percent by the year 2035—an increase of 150 percent.

Although long-term forecasts of medicare's Supplementary Medical Insurance (SMI) program are not available, CBO estimates that the recent rapid growth in SMI expenditures (17 percent annually between 1977 and 1987) will continue in the near term. CBO's most recent projections foresee SMI outlays, net of enrollees' premiums, to rise from .5 percent of GNP in 1987 to .7 percent by 1992. At present, there is little reason to doubt that SMI will grow at a slower rate than HI over the long run, an assumption which implies spending in SMI by 2035 will be 1.74 percent of GNP.[21]

Long-term care.—The aging of the population will increase substantially the need for long-term care (LTC) services, ranging from limited assistance at home with the tasks of daily living to skilled medical care provided in a nursing home or other institutional setting. Spending for LTC for both elderly and nonelderly persons has grown rapidly in recent years, driven by many of the same factors that have pushed up acute-care costs. Public funding for LTC services pays for about half of all spending on long-term care. Total public spending for nursing home care and home health services in 1986 was $25 billion, or 0.6 percent of GNP. Of that amount, long-term care expenses in the Federal-State Medicaid program, the great majority of which goes to finance nursing home care, made up about $20 billion of the total, with the Federal Government paying about 55 percent of that cost. Currently, LTC expenditures account for about 45 percent of all Federal and State medicaid outlays. (States have a great deal of flexibility in setting medicaid rules, however, and the share of total spending devoted to LTC services and the rate of growth in those expenditures varies appreciably around the Nation.)

Remaining public spending for LTC is accounted for by medicare, programs funded under the Social Services Block Grant to States, Veterans' Administration health care, Older Americans Act programs, and resources provided by States and localities out of their own revenues. Private spending for LTC—an amount roughly equal to public spending—is almost all paid out of pocket by patients or their families, rather than through private insurance mechanisms.

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[20] Waldo, Daniel R., and Helen C. Lazenby. Demographic Characteristics and Health Care Use and Expenditures by the Aged in the U.S.: 1977–1984. Health Care Financing Review, v. 6, No. 1, fall 1984.

[21] The SMI projection for 2035 is based on rates of increase for HI provided in the 1987 report of the Social Security Board of Trustees. A similar methodology for projecting SMI growth is presented in Holahan, John, and John Palmer. Medicare's Fiscal Problems: An Imperative for Reform. Washington, The Urban Institute, 1987. p. 7.

In addition, many services are provided without reimbursement by family members or by other informal caregivers.

Demand for LTC services will almost certainly increase steeply in the decades ahead as the number of very old individuals grows. While less than 2 percent of all people between the ages of 65 and 74 reside in nursing homes, 7 percent of all 75- to 84-year-olds and more than 20 percent of all those age 85 or older live in such institutions. Thus, the expected doubling in the number of 75- to 84-year-olds between now and the year 2050, and the projected six-fold increase in the number of people over 85, portend a large potential increase in the demand for LTC services.

Other programs.—The aging of the population will also affect smaller Federal programs. Compared to other spending on the elderly means-tested transfers to the elderly will grow more slowly and could fall as a percent of the GNP. To the extent that real growth in average social security benefits, in public and private pensions, and increased returns on savings continue to shrink the proportion of elderly with very low incomes, spending in such programs as SSI and food stamps will drop. Even today, however, spending for the elderly under these programs is small compared with expenditures for work-related retirement income and health care programs. In 1984, Federal spending for the elderly under SSI and food stamps amounted to only about 0.1 percent of GNP.

Future spending for appropriated programs benefiting the elderly—such as subsidized housing, Veterans' Administration health care, and home energy assistance—is harder to forecast. While growth in the number of elderly could increase the demand for these services, funds would have to be appropriated and will not rise automatically. Instead, their cost will depend on annual funding decisions made by future Congresses.

c. Accommodating increased Government spending on the elderly.—The projected growth in the size of the elderly population in the years ahead will place additional demands on the Nation, but this will not be the first such challenge it has faced. For example, in the 1950s, the United States accommodated large increases in public and private spending on children. Similarly, over the past two decades the Nation adapted to an increase in the size of the elderly population while greatly improving their average standard of living.[22] Although from a much lower base, Federal spending on the elderly actually has increased over the last 20 years by a greater extent than is projected, under the intermediate assumptions, over the next 60 years or so.

Assuming a continuation of current policy, spending for social security and medicare (including SMI) is projected to rise from 6.39 percent of GNP in 1987 to approximately 11 percent by 2035. While smaller than social security, medicare would see the greatest percentage growth. Federal spending for long-term care—though low today compared with either social security or medicare—also could grow explosively with the steep increase in the number of very old.

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[22] The United States also has accommodated significant changes in spending on national defense in relatively short time periods. For example, between fiscal year 1972 at the end of the Vietnam War and fiscal year 1980, such spending decreased from 6.9 percent of the GNP to 5.0 percent. By fiscal year 1986, it has increased back up to 6.6 percent. See, U.S. Congressional Budget Office. The Economic and Budget Outlook: Fiscal Years 1988–1992. Table F-6. January 1987. p. 160.

Faced with these projections of Federal spending on the elderly, several broad choices are available. First, future demographic shifts could be accommodated without changing current public policies, thus allowing the cost of public programs for the elderly to increase relative to the size of the economy. Alternatively, the growth in such programs could be curtailed. That would leave future generations of the elderly more heavily reliant than they would otherwise be on their own resources or on aid from family members. In many instances, this would lead to a lower standard of living—at least relative to pre-retirement standards—for many of the elderly in the future than is enjoyed by today's elderly. A third broad choice would be to encourage—or require—today's working-age population to contribute more in advance toward meeting the needs they will face in their old age. This strategy can be effective in expanding the Nation's future economic base only if the Government does not offset such advance funding with increased borrowing (see section III of this overview and chapter 4 of the background papers). As a consequence, this strategy almost surely would entail higher taxes or decreases in other Government spending. Thus, either some sacrifice in personal consumption or the level of Government services would be necessary.

Of course, projections such as these will be profoundly affected by developments in technology, biomedical research, and demographic conditions. If, for example, birth rates should greatly increase or if immigration should exceed current statutory assumptions, then the future working population and, therefore, the GNP would be larger. Consequently, the cost of Government programs for the aged would be a smaller fraction of GNP. Within any of these broad policy choices, the Federal Government could also alter current programs, the distribution of their benefits, or the manner in which they are financed without affecting total program costs.

2. Income Tax Subsidies

Income tax subsidies—that is, departures from the "normal" principles of income taxation—also affect the income available to the elderly after retirement. These tax subsidies come in two forms: tax benefits designed to lessen the tax burden of older citizens; and tax advantages designed to increase the accumulation of retirement income among today's workers for their future retirement.

a. Tax benefits for older citizens.—The major tax benefits for the elderly have included the exemption from taxation of most social security payments and the larger personal exemption for the elderly. Most social security benefits are excluded from Federal income taxation, and only about one-half of all elderly people pay any Federal payroll or income taxes. About 90 percent of all other adults pay taxes. For fiscal year 1988, the Joint Committee on Taxation estimates that the exclusion of social security benefits (in excess of amounts equal to employees payroll taxes) reduces income tax revenues by about $19 billion.[23]

However, in the future, social security benefits will become increasingly subject to income taxes. Under current law, higher-income taxpayers must include up to one-half of their social security benefits in their taxable income if their income exceeds $25,000 in the case of single filers or $32,000 in the case of joint filers. (For these purposes, income is the combination of their adjusted gross income, one-half of their social security benefits, and any tax-exempt bond interest.) These thresholds, however, are not indexed, and successive cohorts will be including more and more social security in their taxable income.

The Tax Reform Act of 1986 diminished some, but not all, of the provisions benefiting the elderly. Most importantly, the 1986 act eliminated the larger personal exemption for the elderly, substituting a somewhat larger standard deduction for elderly taxpayers who do not itemize their deductions. According to Joint Committee estimates, this new provision will entail an annual revenue lost of $1.3 billion from 1988-1992.

b. Tax advantages for retirement accumulations.—The favorable treatment granted to accumulations in tax-qualified retirement programs—including IRAs—affects the Federal revenue base more than any other tax preference. This favorable treatment exempts from taxation most investment gain accumulated for retirement purposes.[24] The Joint Tax Committee estimates that the 1988 revenue loss associated with qualified plans will total about $58 billion, an amount that is 1.2 percent of GNP.

The 1986 Tax Reform Act curtailed some tax advantages for qualified plans. The principal changes eliminated the deductibility of contributions into IRAs for upper-income taxpayers and diminished somewhat the tax benefits for contributions to employer-sponsored plans, especially salary-reduction plans. Despite these changes, there probably will be an upward trend in the revenue losses associated with qualified plans as baby-boom workers enter into the years in which their pension, IRA, and similar retirement accumulations will be the greatest. Nonetheless, the revenue losses for qualified plans are unlikely to exceed 2 percent of GNP at their peak. In the post-2015 period, the revenue losses from qualified plans will stabilize, even decline, as the Government begins to collect taxes on a bulge in plan and IRA distributions associated with the baby boom's retirement.

A final major tax advantage particular to retirement accumulations is the one-time exclusion, for taxpayers over age 55, of $125,000 (or less) in gain from the sale of a principal residence. This provision, according to Joint Tax Committee estimates, will reduce income tax revenues in fiscal year 1988 by about $2.3 billion.

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[23] This figure includes the parallel exclusion for railroad retirement benefits and the historically associated tax credit for the elderly. The latter credit applies to the pension income and earnings of taxpayers—such as retired Federal employees—who receive little or no social security benefits compared to most retirees. Estimates of revenue losses included in this section are from: U.S. Congress. Joint Committee on Taxation. Estimates of Federal Tax Expenditures for Fiscal Years 1988-1992. Joint Committee Print No. JCS-3-87, 100th Cong., 1st Sess. Washington, U.S. Govt. Print. Off., 1987.

[24] See footnote 14 and the references cited therein for a description of the advantages of tax-qualified plans.

3. Government Guarantees

The Federal Government underwrites certain risks in retirement income accumulations. Some of these guarantees follow from more general policies, such as the protection provided all deposits in financial institutions, including those that are part of people's retirement portfolios, that belong to the Federal Deposit Insurance Corporation (FDIC) or the Federal Savings and Loan Insurance Corporation (FSLIC). Further, institutional and household retirement portfolios are partly invested in different types of Federal obligations which carry the Government's full faith and credit.

In addition, the pension promises that employers make in defined benefit plans are guaranteed to the extent of "accrued benefits" by the PBGC. If financially distressed firms terminate their defined benefit plans, and if the plans have insufficient assets to pay accrued benefits, the PBGC will pay those benefits up to an indexed limit. Because the value of workers' accrued benefits in a defined benefit plan increases with age and job tenure, this protection is especially valuable to people who have already retired or who are relatively close to the plan's retirement age. In 1987 PBGC protection covered benefits, payable at full retirement, equal to, or below, $1,850 per month ($22,200 annually). To fund this protection, PBGC charges employers who sponsor defined benefit plans an annual premium for each covered worker.

Between 1974 and 1986, the PBGC accumulated a deficit of about $3.8 billion. This funding shortfall represents the difference between PBGC's assets of $3.6 billion and the present value of its liabilities to participants in underfunded plans which it has taken over (approximately $7.4 billion). Future claims against the PBGC are very difficult to estimate. They depend on both the overall future of the economy and the market viability of the particular major corporations that primarily sponsor defined benefit plans. Unfunded benefits among private defined benefit plans currently total several billion, but they can vary over time according to contribution adjustments, revisions in plan provisions, and the performance of the financial markets.

The PBGC's protection does not entail the full faith and credit of the United States. Nonetheless, if the defined benefit pension world should begin to seriously contract, future policymakers would be confronted with some difficult choices. For example, if well-funded plans are faced with ever-escalating premiums, resulting from the terminations of some large, seriously underfunded plans, then they might choose to cancel their plans. This would leave PBGC with an ever-declining revenue base. Under these circumstances, Federal policymakers would have to choose among infusions of general revenues, trying to lock-in plan sponsors to preserve the system's revenue base, and having participants receive much lower benefits than they were expecting.

V. INFLUENCE OF INCOME ON RETIREMENT PATTERNS

A. INTRODUCTION

During this century dramatic changes have occurred in the work and retirement patterns of American workers and in the financial resources of older persons. Retirement, once a luxury only a few enjoyed, is now an expected fact of life for the average worker. In addition, in recent years, retiring workers have been leaving the labor force at increasingly young ages, a phenomenon that appears inconsistent with the generally improving health of the population, increasing life expectancies, and improved working conditions.

Access to retirement income sources not available in the past makes retirement economically feasible and in part explains the declining labor force participation of older persons. In the early part of this century older persons who were able to work did so. Many who did not work depended on the support of grown children and family, but others simply spent their last years in poverty. By almost any measure, the overall situation of the aged has changed for the better, although poverty continues to be a problem among certain subgroups of the elderly.

The affluence of today's retirees relative to previous generations and to current workers may be a phenomenon characteristic of this one generation. Most projections into the future assume moderate and sustained rates of economic growth. If it does not occur, today's workers may have relatively less retirement income than their parents, although even low rates of real wage growth will increase the real dollar value of future retirement income.

Today's retirees grew up during the Depression and had their expectations of the future colored by that experience. However, as young adults they entered the labor force around the time of World War II, and the subsequent economic growth of the 1940s, 1950s, and 1960s brought them jobs and prosperity. Employer pension coverage expanded significantly, and social security was liberalized in the late 1960s and 1970s. In comparison, the experiences of the baby-boom generation have been and may continue to be different. If the return to economic growth is not sustained, a comfortable retirement at an early age will be less likely for this generation of young workers.

B. INCOME STATUS OF THE ELDERLY

Evaluating the income adequacy of the elderly as a group takes two perspectives: (1) the income of the elderly compared with that of the nonelderly; (2) the income of the elderly compared with their own income earlier in life.

By either of these measures, the income status of the current generation of elderly persons constitutes a generally comfortable picture. Although the current total household income of the elderly is lower than the income of households headed by nonelderly persons, when the smaller household size and special tax status of the elderly are taken into account, the picture looks quite different. The average gross income of a household headed by someone age 40 to 54 is about twice as high as the average gross income of a household headed by someone 65 or over, but the after-tax, per capita income of elderly households is actually sightly higher than that of younger families ($8,886 in 1984 for elderly households compared with $8,238 for those with a head age 40–54). (Chapter 5 of the background papers discusses this point more extensively.)

The poverty rate measures the income adequacy of given demographic groups. The incidence of poverty among the elderly population has improved substantially in recent years, a further indication of their improved economic status. In 1969 nearly one-fourth of the elderly population lived below the poverty threshold. By 1984 this portion had dropped to one-eighth.

Replacement rates measure post-retirement income compared with pre-retirement income and are used to evaluate the extent to which retirees can continue their pre-retirement standard of living when they no longer have earnings. Replacement rates take into account the somewhat reduced consumption needs of retirees as well as certain tax advantages for the elderly. For example, retirees no longer have work-related expenses such as commuting costs or clothing suitable for work, and generally are freed from costs associated with child rearing and education. In addition, it is usually assumed that retirees no longer need to save for retirement but can begin to draw down savings. Finally, although social security benefits are partially taxable for some upper-income retirees, most beneficiaries pay no taxes on their social security income. Many retirees face lower Federal and State income taxes than they did during their working years and benefit from other special tax provisions.

Although a few researchers have attempted to establish "target" replacement rates to determine what percentage of pre-retirement income is necessary to maintain living standards in retirement, there are no universally accepted replacement rates (nor, in fact, is the measuring period for pre-retirement income generally agreed on). One study suggested replacement rates from about 81 percent for lower-income couples falling to about 66 percent for upper-income workers.[25] Using data from the Social Security Administration's Retirement History Survey, and defining pre-retirement income as the highest 3 years of the previous 10, another study found that the retirement incomes of couples approached target replacement rates except among those with relatively high pre-retirement earnings. Among single women, however, replacement rates fell short at most levels.[26]

C. TO WHAT IS THE IMPROVED INCOME STATUS OF THE ELDERLY ATTRIBUTABLE?

Increasing income from sources other than earnings has made retirement possible and comfortable for many Americans. In general, retirees are financially better off today because they have accrued claims to work-conditioned retirement income, including social security, and have accumulated personal savings. Between 1967 and 1984, the proportion of elderly households receiving social security benefits rose slightly, from 86 percent to 91 percent (see table 6 in chapter 6 of the background papers). However, the average social security benefit for retired workers increased by two-thirds, from about $3,540 in 1965 to $5,858 in 1987 (in 1987 constant dollars). This growth in benefits represents a substantial real increase in benefits resulting from liberalization of the payment formula and real wage growth.

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[25] Testimony of Dr. Alicia H. Munnell, House Ways and Means Subcommittees on Oversight and Social Security, July 18, 1985.

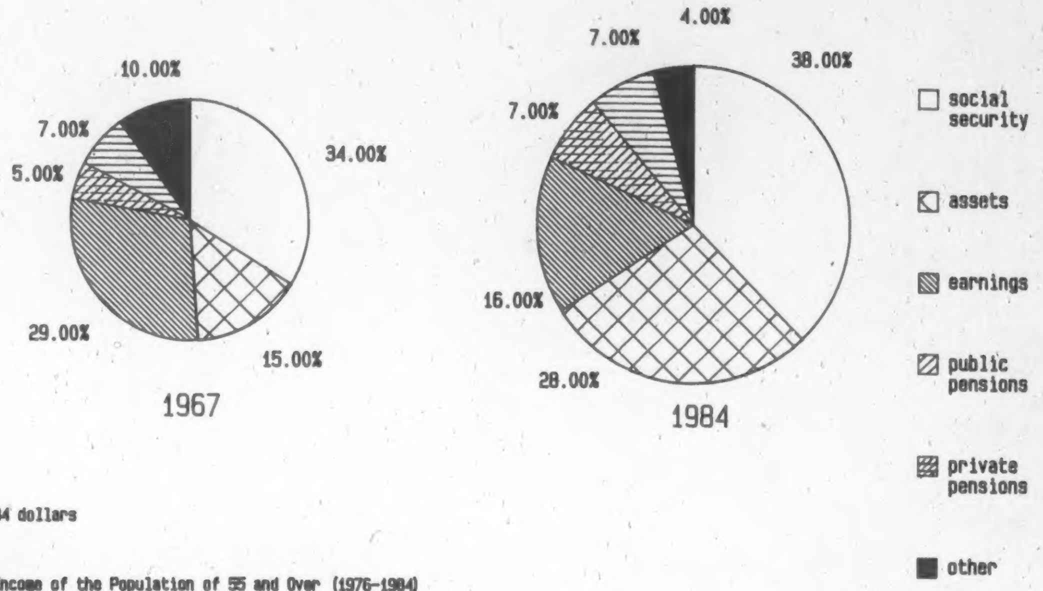
[26] Boskin and Shoven, Concepts of Earnings Replacement.

From 1967 to 1984, social security as a share of all income going to the elderly increased by only 11 percent, from 34 percent to 38 percent (see figure 3). On average, however, benefits increased by about two-thirds in real terms. This indicates that the income of the elderly from sources other than social security has increased as well. Among other sources, the most telling change is the reversal of earnings and asset income as income shares. Twenty years ago, earnings accounted for 29 percent of all income going to households with an elderly member (age 65 or over), and were second only to social security as a share of the income of the aged. By 1984, however, earnings accounted for only 16 percent of the income of elderly households, ranking third as an income share after social security and income from financial assets. Thus, it appears that income from assets has offset much of the decline in income from earnings, as is illustrated by figure 3. Not only is asset income an important source of support for older persons, but it also is received by a substantial portion of elderly households: over two-thirds report receipt of asset income. Although there is a large variance in the amount of asset income received by individual elderly households (and it varies substantially by income level), it is extremely important to today's retirees, accounting for a large share of income received by a significant portion of that population. This sizable asset income may explain much of the labor force withdrawal that has been occurring on the part of men in their early 60s.

Figure 3.

Income Shares of Aged Households a/

(All units, including married couples and nonmarried individuals)



a/ In 1984 dollars

Source: Income of the Population of 55 and Over (1976-1984) and Demographic and Economic Characteristics of the Aged: 1968 Social Security Survey, U.S. Department of HHS.

About one in four elderly persons receives pension income from a private employer, and one in six receives a pension from public sector employment. The proportion of aged households receiving private employer pensions grew significantly between 1967 and 1984, from 12 percent to 24 percent, but, as a percent of all income going to elderly households, private pensions increased only from 5 percent to 7 percent during this time. This indicates that much private pension income is quite small: in 1984 the median private pension was about $2,900 for retirees age 65 and over, and about $4,500 for those age 55–64.

Overall, the points to be made about the income of the elderly are that (1) it has increased substantially over recent decades, but (2) the proportion of income from social security and pensions has changed little, but a significant shift has taken place with decreased earnings and increased asset income in the period. Thus, although it is often maintained that social security has been largely responsible for the improved situation of today's elderly, it has been a more important factor for those without other sources of retirement income than it has been across the entire income spectrum.

D. INCOME DISTRIBUTION AMONG THE ELDERLY

As might be expected, lower-income elderly households rely heavily on social security and public assistance income and have little in the way of asset income (table 2). Social security accounted for 77 percent of the income of those elderly who had incomes below $5,000 in 1984. Although 9 out of 10 elderly households received social security, it accounted for only about one-fifth of the income of the wealthier recipients (those with incomes over $20,000). The data also indicate that the elderly who continue to work generally have higher incomes than those who do not, a factor that is likely to be associated with a history of better-paying jobs, good health, and thus better opportunities for continuing employment.

TABLE 2.—SHARES OF AGGREGATE INCOME BY SOURCES FOR AGED UNITS AGE 65 AND OVER, 1984

[In percent]

Income status	Employment earnings	Social security	Employer pensions or private annuities	Income from assets	SSI	Other	Total
Under $5,000	0	77	3	4	14	2	100
$5,000–$9,999	4	71	8	10	3	3	100
$10,000–$19,999	10	48	17	21	0	2	100
Over $20,000	23	20	16	39	0	1	100
Total	16	38	14	28	1	2	100

Source: U.S. Dept. of Health and Human Services. Social Security Administration. Income of the Population 55 and Over, 1984. SSA Publication No. 13–11871, Dec. 1985.

The economic situation of the over-65 group as a whole is much improved over what it was in past generations, but large disparities remain among certain subgroups of the elderly. In particular, the incidence of poverty remains high among elderly single women. Nearly 20 percent of all elderly women who live alone have incomes below the poverty threshold (a total of 1.4 million women), about double the poverty rate for all elderly people. And, if not actually below poverty, many single elderly women have near-poverty incomes: a total of 44 percent of all elderly widows have incomes below 150 percent of the poverty level.[27] (For additional discussion of poverty and the elderly, see chapter 5 of the background papers.)

The causes of poverty among older women are varied and complex, but a few generalizations can be made. Many have been poor or low income for a large part of their lives. If they spent time in the labor force, it was at low paying and often intermittent jobs; many were married to someone who was a low-wage worker. The low-income and poor elderly did not, in their younger years, have the kind of work and income history that would permit accumulation of savings, pensions and large social security benefits. A recent study on the causes of poverty among widows found that these women are likely to have had husbands whose health was poor, with the concomitant problems of lower earnings, less savings (or perhaps depleted savings), early labor force withdrawal due to health factors and early death.[28] About half of poor widows had been poor before widowhood, and half became poor upon widowhood either through lack of accrual of retirement income or because of medical and death expenses. Recent legislation requiring that the election or rejection of a spouse survivor benefit be a joint decision by husband and wife will have little effect on such survivors because, for many, no pension rights were accrued and, for others, the pension benefits are not large enough to provide a survivor benefit of any size.

Review of the income sources of the poor and nonpoor elderly who live alone (80 percent of whom are women) indicates how important social security is to these people (table 3). Social security represents an estimated 79 percent of the income received by single elderly persons living alone and below poverty; in comparison, it represents an estimated 22 percent of the income of those who might be classified as moderate to high income ($16,224 and over per year). It is estimated that about one-third of this population receives public assistance (principally SSI), and, in combination with social security, these two sources make up 93 percent of the income of the poor, single, elderly population. Thus, in spite of receiving social security and SSI, many elderly remain in poverty. This is true because basic Federal SSI benefits (currently $340 per month for a single individual) are below the poverty threshold, and they are reduced dollar-for-dollar by any social security the individual receives in excess of $20.

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[27] The Commonwealth Fund Commission on Elderly People Living Alone. Old, Alone and Poor. A Plan for Reducing Poverty Among Elderly People Living Alone. (Technical analyses by ICF, Inc.) Baltimore, April 1987. (Hereafter cited as Old, Alone and Poor)

[28] Hurd, Michael, and David Wise. The Wealth and Poverty of Widows: Assets Before and After the Husband's Death. Draft report to the Commonwealth Fund Commission on Elderly People Living Alone.

TABLE 3.—RELATIVE CONTRIBUTION OF INCOME SOURCES FOR PERSONS AGE 65 AND OVER LIVING ALONE, 1987

[In percent]

Poverty status	Employment earnings	Social security	Employer pensions	Income from assets	SSI	Other	Total
Poor [1] (under $5,408)	1	79	3	3	14		100
Near poor [2] ($5,409–$8,112)	3	81	6	8	2		100
Modest income [3] ($8,113–$16,224)	7	56	13	21		3	100
Moderate-to-high income [4] (over $16,224)	12	22	13	52		1	100
Total	9	40	12	37	1	1	100

[1] Estimated poverty threshold for single elderly persons in 1987.
[2] 100 percent to 150 percent of poverty.
[3] 150 percent to 300 percent of poverty.
[4] Over 300 percent of poverty.
Source: Estimates prepared for the Commonwealth Fund Commission on Elderly People Living Alone (1987) by ICF, Inc. Estimates are based on Current Population Survey (CPS) data adjusted for survey underreporting.

Under projections of social security benefits published by the Social Security Trustees based on their intermediate assumptions and projections of income from all sources by ICF, Inc., also using the Social Security intermediate assumptions, future generations of elderly persons will be better off in real terms than today's retirees.[29] Nevertheless, poverty among elderly people living alone and among women in particular is potentially a problem that will persist into the first decade of the next century; it would persist if (1) women continue to work less steadily and at lower-wage jobs than men and thus qualify for lower social security and pension benefits, and (2) if working women continue to be employed in industries with low pension coverage rates. Various projections of real wage growth indicate that the elderly in the future will have larger retirement income in real dollars than today's retirees, and that the poverty rate among elderly as a group would consequently fall. However, increases in retirement income for elderly single women might not improve accordingly because, in spite of increasing labor force participation among women, many may continue to have relatively sporadic attachment to the labor force and earn relatively low incomes.

E. RETIREMENT: PAST TRENDS AND FUTURE DIRECTIONS

If projected rates of continued economic growth far into the future do not materialize the baby boom will approach their retirement years with fewer sources and lower amounts of retirement income compared to today's retirees. The current generation of retirees has benefited from uniquely favorable economic conditions. They participated in economic growth during their early adulthood, realized significant real wage growth, were able to buy homes at an early age, and accrued savings in financial assets. The rise in interest rates that began in the late 1970s and continued through the early 1980s allowed their savings to compound and grow in the years just before retirement and in early retirement when their consumer spending was declining. Thus, it has been possible for them to supplement their income with large returns on their savings. As a result, the current generation of retirees entered their later years with appreciable personal financial resources in addition to substantial social security benefits and the assurance that their social security would maintain its purchasing power. Hence, they could afford to retire early, and such a trend became apparent in the 1970s.

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[29] Old, Alone and Poor. In the preparation of this report, the Commission contracted with ICF, Inc., a research-consulting firm, for estimates and projections pertaining to income sources and amounts for the elderly population. ICF data are included as an appendix to the Commission report. When used in this paper, these estimates and projections will be referred to as prepared by ICF, Inc.

1. Past Retirement Trends

The increase in the incidence of retirement and the trend toward earlier retirement among American workers are readily apparent from historical labor force participation data (see chapter 6 of the background papers). Only 16 percent of men age 65 and over were in the labor force in 1985. This is one-third the rate for this age group 35 years earlier. Bureau of Labor Statistics (BLS) data also show a clear trend toward retirement before age 65. The labor force participation of men between the ages of 55 and 64 dropped by over one-fifth between 1950 and 1985, much of which can be attributed to social security's becoming available to men at age 62 as of 1961.

Looking ahead toward the retirement of the baby boom in the first decades of the next century, a critical issue is whether these trends toward early labor force withdrawal will continue, stabilize, or possibly reverse. The trend toward retirement at younger ages causes concern as the retirement of the baby-boom generation approaches and raises the specter of an increasingly large group of older nonworkers dependent on a comparatively small labor force (chapter 3 of the background papers analyzes measures of "dependence" in detail). To the extent that members of the baby boom are currently building up claims for future retirement income, continuation of recent early retirement trends raises serious questions about whether the resources will be available to meet the claims of an unprecedented number of retirees. Projections by the Social Security Trustees and others, based on the growth rates of intermediate assumptions, show that over their remaining working years the baby boom will realize real growth in their retirement benefits and will accrue adequate resources for a comfortable retirement. But the extent to which the baby-boom generation reaches retirement with the private resources to provide for themselves will depend in large part on whether this projected economic growth actually materializes.

2. Early Retirement and the Baby Boom

Thus far, as young adults the baby-boom generation has experienced low real wage growth since they entered the labor force in the 1970s. Unless the future holds a return to sustained periods of economic growth, they may be in a very different position from today's retirees as retirement age approaches. Large, ad hoc increases in social security replacement rates such as occurred in the late 1960s and early 1970s are unlikely to occur again. But if income from pensions and social security grows enough as a share of income of the elderly, and if individual savings pick up as the baby boom enters its peak earnings years, they may have high enough incomes to support continued early retirement. If not, they may choose to work longer. In fact, in recent years, legislation has been enacted with incentives for older workers to remain on the job as they approach the age at which they might begin to think about retirement, including: (1) a gradual increase in the age for full social security benefits to age 67 by 2027, (2) a gradual increase in the delayed retirement credit for workers who continue to work beyond the age for full social security benefits (to be fully phased in by about 2008), (3) liberalization of the social security earnings test (beginning in 1990), (4) elimination of mandatory retirement at age 70 under private pension plans, (5) the requirement that private pension plans allow workers to continue to accrue retirement credit if they work past the normal retirement age, and (6) reduction in the time period required for a worker to become vested in a private pension plan.

3. Trends in Pension Income

Private pensions will continue to be an important source of income for the baby boom, but their importance in relation to other sources of retirement income may have been exaggerated.

Although the formation of new employer pension plans seems to have leveled off, more of today's workers will reach retirement having worked in jobs covered by a pension plan than did past generations of workers. In 1984, 40 percent of elderly household units reported receipt of pension income from public or private sources.[30] However, projections indicate that, over coming decades, growing proportions of retirees will receive pensions. For example, projections of pension receipt prepared by ICF, Inc., for the Commonwealth Fund Commission on Elderly People Living Alone indicate that about by the year 2020, 63 percent of all elderly people could receive a pension from private or public employment.[31] However, even though more elderly workers may qualify for a pension in the future, those benefits will not necessarily be large. For example, the portion of the elderly receiving a pension increased substantially from 1967 to 1984, but private-employer pensions grew to one-fourteenth of all retirement income. The ICF projections indicate that this could continue to be the case as the baby boom retires in the next century. The ICF study estimates that income from private and public pensions combined will not rise substantially above their current share of income sources of the elderly (about 15 percent). Therefore, in spite of increasing pension receipt, the pensions received by future retirees will likely continue to be modest as a share of their total income.[32]

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[30] U.S. Dept. of Health and Human Services. Social Security Administration. Income of the Population 55 and Over, 1984. SSA Publication No. 13-11871, Dec. 1985.

[31] Old, Alone and Poor, table B-5.

4. Projections of Future Labor Force Participation

As labor force participation declined between the 1960s and the 1980s, earnings dropped as an income share of the elderly, and income from assets increased. The projections into the future indicate that asset income will continue to grow and that social security will remain about the same as a share of income of the elderly in 2020. Earnings will decline somewhat, with some of the share of income they currently represent being replaced by the increase in assets. However, there is also the possibility that, as more workers anticipate receiving an employer-provided pension, personal retirement savings will decline.

TABLE 4.—LABOR FORCE PARTICIPATION RATES FOR OLDER MEN, 1985–2020

[In percent]

Age	ICF/BLS [1]			SSA [2]		
	1985 (actual)	2000 (projected)	2020 (projected)	1985 (actual)	2000 (projected)	2020 (projected)
55 to 59	79.6	76.7	(3)	79.6	76.2	74.1
60 to 61	68.9	54.0	(3)			
60 to 64			(3)	55.7	51.9	51.1
62 to 64	46.1	34.8	(3)			
65 to 69	24.4	14.2	(3)	24.2	22.2	19.1
70 to 74	14.9	11.3	(3)			
70 plus			(3)	10.5	10.7	9.1
75 plus	7.0	6.4	(3)			

[1] Old, Alone and Poor. Report of the Commonwealth Fund Commission on Elderly People Living Alone. April 1987. p. B–6. Projections by ICF, Inc. based on BLS data and adjusted to account for 1983 Social Security Amendments and elimination of age 70 mandatory retirement and projected to the year 2000. Labor force participation defined as the average annual participation as determined from the Current Population Survey (CPS).

[2] Economic Projections for OASDHI Cost and Income Estimates: unpublished data prepared for the 1987 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. (Based on Alternative II–B Economic Assumptions. Includes elimination of mandatory age 70 retirement and other changes made in the 1983 Social Security Amendments.) Labor force participation defined as the average annual participation as determined from the CPS.

[3] No change.

Forecasts about future labor force participation among men in their early 60s differ. For example, projections based on BLS data and adjusted to account for the new retirement legislation show that the labor force participation rate of men age 60–61 will decline by about 22 percent between 1985 and 2000 (from 69 percent to 54 percent), and that the decline among those age 62–64 will be nearly 25 percent by the turn of the century (from 46 percent to 35 percent).[33] The projections about somewhat younger men (age 55–59), however, show a modest decline of 3.6 percent in the same time period. (See table 4). Other projections show a less steep decline and a leveling of the early retirement trend. The Social Security Administration (SSA) estimates that the labor force participation of men 60–64 will decline by about 8 percent from what it was in 1985 to the year 2020 (table 4), and that the average age at which social security retirement benefits are drawn will be about the same in the early decades of the next century as it is today.

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[32] The data are generated by the ICF, Inc., PRISM microsimulation model. For the reasons discussed in section VI, these projections may overstate the growth in income form private defined benefit pension plans. These simulations also may underestimate the extent to which pensions substitute for personal savings.

F. CONCLUSIONS

Projections of the income of future retirees are highly dependent on the assumptions used about the future of the economy and real wage growth in the next decades. The projections are based on the Social Security intermediate assumptions, and include real wage growth of about 1.5 percent annually between now and 2020, which is large enough to compensate for the periods of negative and very low wage growth today's young workers have experienced since they entered the labor force. Under these projections, it seems reasonable that the size of social security benefits will support continued current early retirement rates for future retirees.

However, the retirement decision seems to be highly conditioned by the availability of unearned income and primarily by asset income, and the decisions that will be made by members of the baby boom as they reach retirement age will depend heavily on their individual retirement savings, which also are strongly linked to real wage growth. If the economy performs more poorly in the future than the Social Security intermediate assumptions indicate, it is possible that earnings and assets, as portions of the retirement income pie, could reverse positions again, and early retirement trends could slow or reverse. If problems of income adequacy and distribution become apparent, Federal programs and policies can be adjusted as the need arises. However, to some extent, the labor force participation of older workers self-adjusts to their economic situation.

It is extremely difficult to quantify and incorporate behavioral and attitudinal changes that may occur in society into mathematical forecasting models. The important point here is that labor force participation and retirement rates in the future cannot be predicted with certainty, but are conditioned by a large number of economic and behavorial factors: labor market conditions, economic circumstances during a worker's lifetime that permit the accumulation of personal savings, availability and generosity of public programs for the elderly, and attitudes about work and retirement.

In addition, retirement trends themselves can change the relative attractiveness of retirement versus continued work. A positive correlation exists between amount of education and length of work career. Thus, the relatively high educational status of the baby boom may support delayed retirements. Furthermore, labor shortages could develop as the baby-boom generation prepares to leave the workforce. If the following generation cannot fill the demand for labor, it is likely that wages would rise, employers would restrict use of early retirement options in their pension plans, and older workers would be induced to remain on the job.

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[33] Old, Alone and Poor, p. B–6. The BLS makes no projections beyond the year 1995. The ICF, Inc. projections simply extend those done by the BLS to the year 2000, and assume that labor force participation rates beyond that time remain about constant.

CHAPTER 4. PREPARING FOR THE RETIREMENT OF THE BABY BOOM: SAVING AND INVESTING*

The demographic trends described in chapter II imply a sharp increase in the retired population in comparison to the workforce beginning about 25 years from now. This chapter is concerned with delineating the role that national saving and investing can play in preparing for the baby boom's retirement years (and beyond). Supplementary policies to raise retirement ages and increase the labor force are considered in other chapters. After some introductory remarks concerning the roles of domestic and foreign investment, a strategy for the timing of investment is presented. This is followed by a summary of the state of knowledge on trends in saving behavior. The chapter concludes with an overview of past trends and future prospects for economic growth.

I. STRATEGY FOR THE BABY BOOM'S RETIREMENT

A. HOUSEHOLD RETIREMENT PLANNING

National planning for retirement of the baby boom has much in common with individual planning for retirement. Persons planning for retirement would be advised by experts to work backward from their ultimate goals. What level of bequests do they hope to make? What level of income do they seek in their retirement years?

Having determined these goals, the household—given enough time and subject to a number of constraints—can arrange its economic behavior prior to retirement to attain them. These arrangements can usually be divided into two categories: enhancement of household income from productive activity and accumulation of claims on others.

1. Income From Production

Until recent times, the major form of support for retired people was income earned by their children. "Family planning" for retirement meant having enough children—measured by number or by income-earning potential—to support both themselves and their parents. In modern times, a family business can play the same role. During the family's lifetime, its business would be built up and, at retirement, the household would derive income from its continuing profits.

2. Claims on Others

As societies and economies grew more complex, new avenues of support for retirees became possible. During their working lifetimes today, most people accumulate claims against others that can be converted into income during retirement. These claims can take many forms such as pensions, stocks, bonds and other loans, annuity contracts, and other financial assets, as well as such government-provided assets as eligibility for social security (or other public pensions) and entitlement to various forms of in-kind aid (Medicare, for example). The common note in these sources of support is that the retired household itself does not have to be productive during retirment but can convert its stored, past productivity into income during retirement by exercising claims against others.

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*This chapter was prepared by Robert Hartman and Larry Ozanne, Congressional Budget Office.

3. The Need to Save

All these forms of household provisions for retirement require that part of income be withheld from consumption during the working years. Whether people are sending a child to school, plowing earnings back into the haberdashery, or buying bonds—none of these can be done without curtailing personal consumption—that is, without saving.

B. NATIONAL PLANNING FOR RETIREMENT

Not too much changes when we look at how a nation can prepare for the retirement of some of its citizens, although the demarcation lines (for claims on "others," e.g.) need to be modified. The provision of enough income for the baby boom cohort in its retirement will require saving to fund some combination of net domestic and foreign investment.

1. Net Domestic Investment

One way for the Nation to ease the burden of providing for the baby boom's retirement is to build up the Nation's productive capacity over the next quarter century. By so doing, real GNP (per worker) would be high enough to offset the expected decline in the workforce relative to the retired population, providing adequate real income for both groups.

Certainly a key to the productive capacity of the economy is the amount of private sector capital in the form of factories, equipment, and structures. But a full accounting of the Nation's productive capacity would also make due allowance for the skills of its workforce (human capital) and the aids to commerce that are collectively owned (infrastructure). In the United States these are predominantly financed through the public sector.

2. Net Foreign Investment

Opening up the economy to international trade and capital movements is analogous to allowing the household to go beyond reliance on its children and family-owned business. Specifically the accumulation of foreign assets for the purpose of liquidating them during the baby boom retirement represents a way for the United States to live beyond its domestic productive capacity when it will need it most.[1]

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[1] It goes without saying that translation of the claims on foreigners into imports presupposes a continuation of open markets for trade in goods and services as well as capital movements among nations.

How is this done? The key to understanding the role of the international sector in providing assistance to the baby boom's retirement is to recognize that international trade balances (and their mirror images—international capital movements) allow a nation to consume goods and services at a different time from when it produces them. Thus, when the United States exports more goods than it imports (concomitantly leading U.S. residents to accumulate claims on foreign countries), production exceeds consumption. And when the U.S. imports more than it exports, paying for the excess by decumulating the previously earned claims on foreign countries or accumulating debts to foreigners, it consumes more than it produces.

It follows that one of the ways that the baby boom's retirement can be eased for U.S. residents is to raise the rate of investment abroad—that is, run export surpluses—in advance of that period in the expectation of engaging in foreign disinvestment—an excess of imports—during the baby boom retirement period. This would allow U.S. consumption to exceed productive capacity as its labor force shrinks relative to consumption needs during those years.[2]

C. PROVIDING FOR FUTURE GENERATIONS

One element of the household's retirement plans—bequests—has been neglected in this discussion of national planning, but it has an important role. United States policy cannot singlemindedly focus on the preparation for and duration of the baby boom retirement years as if there was no concern beyond them. If it could, U.S. policy would be enormously easier: between, say, 2010 and 2030 the United States could just borrow whatever it needs from abroad and forget the consequences. Those consequences, of course, would be that the generations from 2030 on would have to export billions of dollars of U.S. produced goods as foreigners liquidated the claims that were acquired in 2010–30.

As part of the Nation's planning for the baby boom retirement, therefore, it must be kept in mind that a legacy is owed to those who live after 2030 in the form of domestic capital and claims on foreign assets. It is well beyond the scope of this chapter to discuss how big a bequest is desirable. But we can make two observations. One is that the United States population in 2030 will be considerably larger than it is today (25 percent larger under the IIB projections discussed in chapter II). Thus, to leave future generations as well off as today would require a 25 percent increase in capital to keep pace with population growth. Second, for as long as American economic statistics have been able to track it, each generation has left its children a larger capital stock than it inherited.

Suffice it to say, then, that one constraint on U.S. retirement goals for the baby boom is that at the end of their lives, enough capital—meaning private/public, human/physical, domestic and U.S.-owned foreign—should have been left in place to have kept pace with population growth and then some. Thus sufficient saving and investing is needed to accommodate both the baby boom's retirement and the needs of future generations.

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[2] An import surplus during the baby boom retirement years does not necessarily mean importing more Mercedes to Palm Beach. It could mean importing more French diapers thereby releasing workers from the U.S. diaper industry who could be absorbed as caregivers in nursing homes. No one would have to plan such resource reallocations; relative prices in domestic and in foreign exchange markets would guide them.

D. A TIMING STRATEGY FOR THE BABY BOOM'S RETIREMENT

When should the saving and investment be undertaken? Specifically, consider the period from 1987 to 2010 and the period 2010–30. In projections for the first period, the labor force grows more rapidly than the overall population (though not as rapidly as in the past 20 years), the ratio of those of retired age to the total population grows slowly, and the workforce composition is sharply improving in experience and educational attainment (which usually also means productivity). After 2010, the workforce grows much more slowly than total population, the ratio of retirement-aged people to the total population grows sharply, and the composition of the workforce in terms of experience levels out.

These demographic recountings should make it clear that it is in the earlier period that the bulk of the targeted growth in capital stock should occur if living standards are to be maintained and if internal conflicts are to be minimized. This is easier to see if one imagines that all of the growth in the capital stock were to be in the form of net foreign investment. In that case the demographic trends imply that the optimum timing strategy would be for the pre-2010 period to be devoted to export surpluses (when the labor force is growing relatively rapidly) and then, conversely, for imports to exceed exports during the baby boom retirement years. In the latter period, foreign productive capacity would be used to supplement an American economy in which the demands of a rapidly growing retirement population would otherwise strain available resources. Doing otherwise—running import surpluses now and export surpluses during the baby boom retirement period—is almost certainly a recipe for conflict. Under that strategy, U.S. output in the post-2010 period would have to be divided not only between the workforce (and its children) and the growing retired cohort but also by foreigners whose export demands would have to be satisfied.[3] Thus, under the optimum strategy, to the extent possible, national policy should tilt toward—or at least not deter—a high investment economy in the period from now to 2010. This means an economy with high total saving as well and this is the obvious cost and limitation on an all-out devotion to this effort. The strategy outlined here necessarily means deferring some consumption (either private or public) over the next quarter century. This can be done through higher voluntary saving by individuals or collective saving through higher taxation or reduced government consumption. Such savings would store resources in the form of human or business capital, infrastructure or claims on foreigners to be realized when the baby boom retires.

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[3] The only circumstance in which it would be advantageous to borrow from abroad in the early period would be if investment opportunities in the United States were unusually high in the immediate period and if domestic savings were unavailable. In that case, early borrowing from abroad would help sustain domestic investment and, if the return is high enough in added capacity, more than pay for the exports later needed to meet the accumulated claims of foreigners. In this case as well as the one highlighted in the text, net investment (here domestic) is kept high in the pre-baby boom retirement period.

E. PROSPECTS FOR HIGH SAVING, INVESTMENT, AND GROWTH

Instead of building up wealth more rapidly in preparation for the baby boom's retirement, the United States has been moving in the opposite direction. Some signs of a moderation or reversal exist, but there is no assurance they will be sufficient to reach historical rates of accumulation and economic growth, much less exceed them, without further policy intervention.

In recent years the United States saving rate has been declining, productivity growth has slowed markedly from the early post-war period, and the United States has become a net borrower from abroad. Total United States saving—that of individuals, businesses, and governments—remained stable relative to the size of the economy during the 1950s, 1960s and 1970s. Since 1980, however, there has been a sharp deterioration (see table 4.1). The predominant source of the lower saving rate has been the sharp increase in the Federal deficit.[4] The decline in saving has necessitated a decline in investment. The decline in domestic investment has been less dramatic than the decline in saving, while the decline in our investment abroad has been greater. Whereas in 1960s and 1970s the United States was accumulating assests abroad (positive amounts for foreign investment in table 4.1) this has sharply turned around in the 1980s; the United States is currently borrowing abroad.

Projecting future saving, investment, and economic growth is notoriously difficult, but some signs point to a moderation or reversal of recent trends. The saving rate may recover some in the near term now that the Federal deficit has stabilized and targets for deficit reduction are being pursued. (However, the size of those deficits and the likely paths of reduction mean that over the 1987–1992 years the Federal budget will—compared to post-war averages—be draining from rather than adding to saving for the baby boom's retirement.) Over the longer run, private saving may be modestly boosted as the baby boom moves into the life stage at which savings rates are highest. Productivity growth may also rise partially back to its post-war average as many of the factors contributing to the past slowdown are reversed. Finally, increased saving in the United States should reduce borrowing abroad and facilitate the buildup of claims abroad. The Japanese particularly (and West Germans to a lesser extent) will undergo a huge increase in the ratio of elderly to workingage population 10 to 20 years before the United States which should reduce their saving and increase their imports, thereby helping U.S. exports and our building up of claims abroad. (The imminent retirement booms in Japan and Germany may help explain their current build-up of exports and claims abroad.)

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[4] The aggregation of savings by decades and into only two components masks some trends that are discussed in the following section on savings.

TABLE 4.1.—TRENDS IN U.S. SAVINGS AND INVESTMENT, 1950–86 (SAVING AND INVESTMENT AS PERCENTS OF NET NATIONAL PRODUCT)

Years	Net private and State/local saving [1]	Federal surplus deficit [2]	Total net U.S. saving [3]	Net private domestic investment	Net foreign investment
1950–59	8.0	0	8.0	8.1	0.2
1960–69	8.9	−.3	8.6	7.8	.6
1970–79	9.8	−1.9	7.9	7.7	.2
1980–86	8.4	−4.7	3.7	5.4	−1.7
1986	7.6	−5.4	2.2	6.1	−3.8

[1] State and local government saving is primarily surpluses in employee pension funds.

[2] Deficits are negative amounts.

[3] As defined in the National Income Accounts, total net saving (column 3) equals private net domestic investment (column 4) plus net foreign investment (column 5) except for statistical discrepancies.

Source: National Income and Product Accounts data compiled by Congressional Budget office.

These anticipated changes probably will not generate the rates of saving and productivity growth needed to prepare for the baby boom's retirement. Thus, policies to increase rates of saving and productivity growth may be of interest. The remainder of this chapter reviews past trends in saving and economic growth, considers prospects for the future, and assesses past policies to alter savings.

II. The Saving Rate: Past Experience and Future Prospects

From the late 1940s until the 1970s the United States saving rate remained stable except for fluctuations with the business cycle. Since the mid-1970s, however, the saving rate has fallen substantially. The largest component of that decline is increased Federal borrowing, although private saving has also declined. During the entire post-war period the saving rate has responded quickly and substantially to changes in the Federal deficit. Other major changes that might have been expected to cause large shifts in saving apparently have had minor effects, such as the expansion of Social Security and employer pensions and changes in the rate of return on saving. Consequently, prospects for increases in the saving rate seem to depend most heavily on reductions in the Federal deficit. The baby boom's movement through middle age may also lift the U.S. saving rate over the next 20 years.

This discussion begins with a review of post-war trends in the U.S. saving rate and its major components. It then reports on events since World War II that might have been expected to influence personal saving.

A. TRENDS IN UNITED STATES NET SAVING

What is measured as U.S. net saving is the domestic funds available each year for investment in private capital formation. This saving is net of that needed to replace depreciating assets, so it is saving available for new investment. Saving by individuals, called personal saving, is the largest component followed by corporate savings as measured by retained earnings—that is, profits not paid out in dividends. Surpluses or deficits of governments are included because deficits are financed by the sale of bonds which absorbs private saving and leaves less for private investment. By the same token, government surpluses make saving available for private investment by retiring public debt or directly as when State and local government pension funds invest in corporate securities. Thus the total U.S. saving rate can be thought of as having four main components: personal saving, corporate saving, the Federal Government's surplus or deficit, and State and local governments' surpluses or deficits. Trends in each of these components are examined below. In this examination saving is measured as a rate of saving out of net national product[5] using National Income and Produce Account (NIPA) data.

1. Total Saving and the Federal Budget

The total U.S. saving rate has averaged 7 to 8 percent of net national product since World War II; in particular years, the rate has surpassed 12 percent and fallen nearly to 2 percent. Most of the fluctuations have been associated with exceptionally large surpluses or deficits of the Federal Government (see figure 4.1), and the swings in the Federal budget have mostly coincided with the business cycle. Thus the recessions in 1949, 1953–54, 1957–58, 1974–75, and 1981–82 led to sharp increases in Federal deficits and consequent declines in the U.S. saving rate in those years. Similarly, economic upturns starting in 1947–48 and again in the early 1950s led to sizeable budget surpluses and upswings in total U.S. saving. The economic upswing from 1975 through 1979 reduced the Federal deficit and also led to an upswing in total saving although the budget remained in deficit. Only the upswing in total saving that occurred in the mid 1960s is not associated with fluctuations in the Federal deficit.

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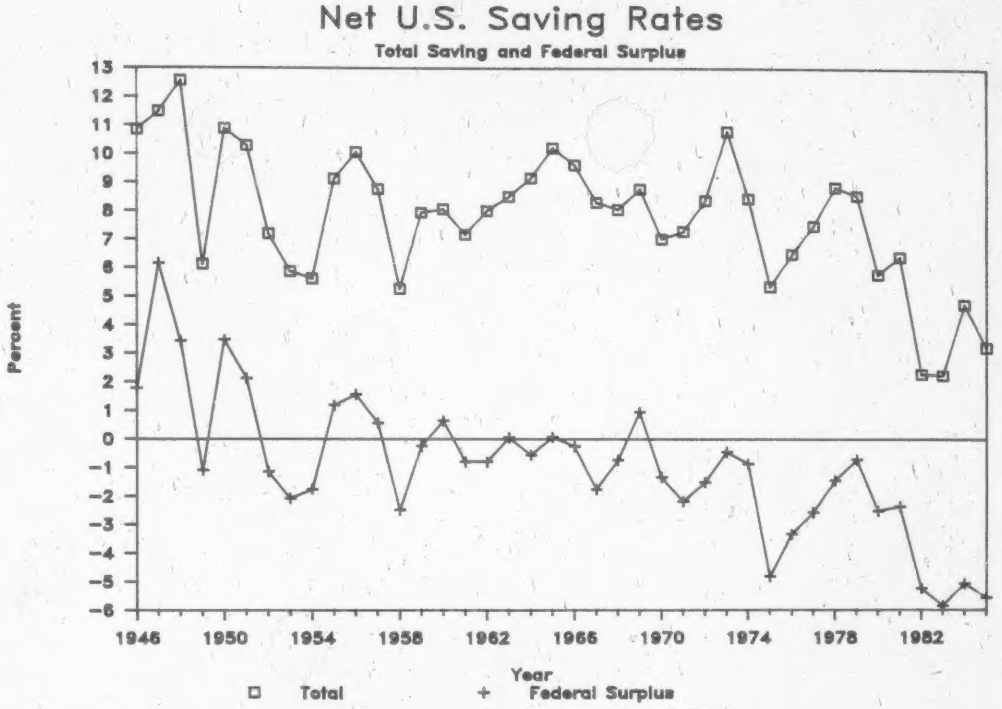
[5] Net national product equals gross national product less depreciation on private capital.

Figure 4.1.



Source: U.S. Department of Commerce National Income and Product Accounts, 1986.

The Federal budget has been in deficit since 1969, and since 1983 for the first time in the post-war era the large deficits associated with a recession have not been reduced significantly by the subsequent recovery. The deficits have been associated with a decline in saving since the early 1970s and particularly since 1982 (figure 4.1). The failure of the deficit to swing sharply back towards balance with the economic recovery since 1982 is due largely to the enactment of tax cuts and tax indexing in 1981 without similar reductions in spending. High interest rates also contributed. The Balanced Budget and Emergency Deficit Control Act of 1985 legislated that deficits be reduced progressively to zero by 1991, but experience since then suggests that deficit reduction will be more drawn out. A large reduction in the deficit would be likely to raise U.S. saving significantly, while continued deficits would seem to continue to depress total saving.[6]

2. State and Local Budget Balance

The budget behavior of State and local governments has been substantially different from the Federal Government's. As shown in figure 4.2, the total surplus or deficit of all State and local governments stayed well below one percent of net national product until the 1970s and since then a surplus has steadily risen, reaching almost 2 percent in 1985.[7]

The growing surplus of State and local governments is due to their buildup of social insurance trust funds, nearly all of which is in pension funds for State and local employees' retirement. Data on the size of these trust funds is available only since 1958, but it shows a steady upward trend since then (see figure 4.2). Total State and local surpluses and deficits have fluctuated around the rising surplus in the trust funds, showing that State and local governments have continued to keep operating budgets near balance in spite of the build up in social insurance funds.

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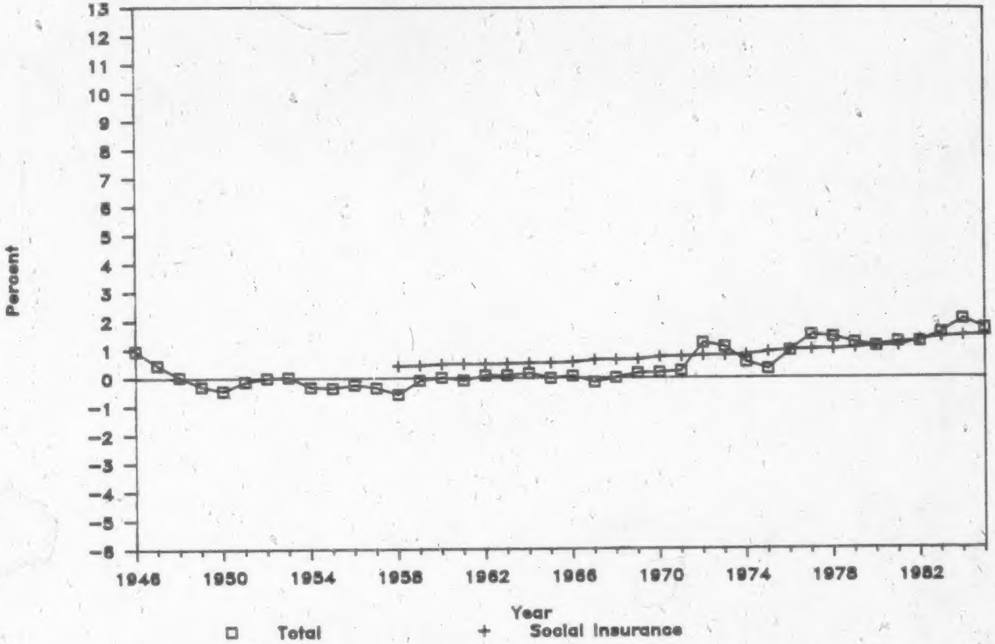
[6] Some analysts have suggested that increases in the Federal deficit would cause people to increase their personal saving in anticipation of the higher taxes that would be necessary in the future to pay off the higher debt. If people followed this course, an increase in the Federal deficit would not lower total saving, nor would a reduction in the deficit raise total saving. The failure of personal saving to rise since 1982 in response to the unprecedented Federal deficits of these years has cast serious doubt on this hypothesis. For further discussion see James M. Porterba and Lawrence H. Summers. Recent U.S. Evidence on Budget Deficits and National Saving. National Bureau of Economic Research Working Paper, no. 2144, Feb. 1987.

[7] The surpluses and deficits of State and local Governments fluctuate with the business cycles of the economy, but the size of the fluctuations are much smaller than those of the Federal Government. State and local Governments, some of whom are constrained by balanced budget laws, have responded quickly to recessions by raising taxes and holding down spending to reduce deficits, and they have reversed course during prosperity. The Federal Government, instead, has used its budget as a counter-cyclical weapon, even augmenting the tendency for the deficit to increase in a recession by voting additional spending and tax reductions. State and local budgets have also fluctuated less than the Federal deficit over the business cycle because their outlays and revenues are less sensitive to economic fluctuations. Moreover, the total of their budgets is smaller than the Federal budget. Total State and local budgets have fluctuated between half and two-thirds of the Federal budget on a NIPA basis (which counts Federal grants that support State and local government spending only as spending for State and local governments).

Figure 4.2.



State and Local Surplus

Total and Social Insurance Funds

Source: U.S. Department of Commerce National Income and Product Accounts, 1986.

Because the State and local budget surpluses represent retirement saving for their employees, their surpluses are likely to continue rising until the baby boom retires. Public plans are less than fully funded in most cases, however, and increased funding by State and local governments could increase national savings. Because State and local governments have tended to keep their operating accounts in balance, they are unlikely to offset any increased pension contributions with greater deficits in other accounts. Their employees would also be unlikely to offset this increased saving with less saving of their own because the increased funding would not be providing increased benefits.

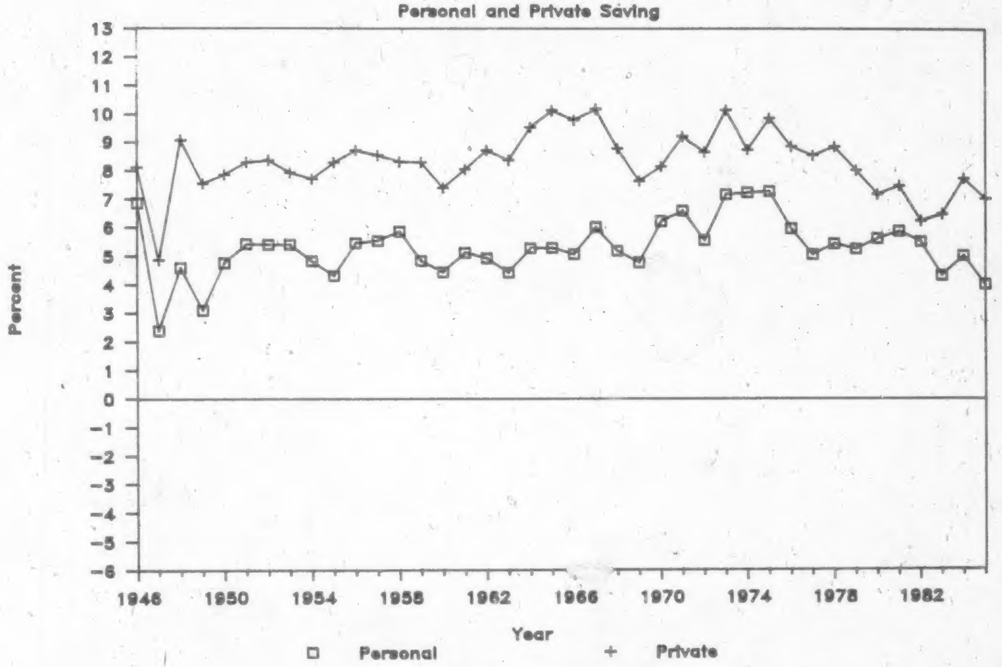
The possibility of raising a budget surplus to fund future retirements can be extended to Social Security. From now through the first decade or two of the next century the Social Security Old Age, Survivors, and Disability trust funds are scheduled to operate with surplus receipts. If the surpluses are not offset by higher deficits elsewhere on Federal accounts, they will raise national saving, investment, and economic growth which will ease the burden of supporting the baby boom's retirement. However, if the surpluses are offset by other Federal deficits, no increase in saving will have occurred. In effect, the payroll tax will be funding other spending by the Federal Government.

3. Private Saving

Like the surpluses and deficits of State and local governments, private savings has been stable compared to the large fluctuations in the Federal surplus or deficit. For most of the post-war era, the private saving rate has been in a narrow range between 7 and 10 percent of net national product, largely due to the stability of its major component, personal saving. The top line in figure 4.3 shows private saving and the lower one shows personal saving; the difference is corporate saving (retained earnings). Offsetting changes in the personal saving rate and the corporate saving rate over the business cycle have also moderated fluctuations in private savings. In a recession individuals tend to save more causing the personal saving rate to rise whereas retained earnings of corporations fall, causing an offsetting decline in corporate saving.

Figure 4.3.

Net U.S. Saving Rates



Source: U.S. Department of Commerce National Income and Product Accounts, 1986.

Although the private saving rate has changed relatively little since World War II, it showed a slight upward trend from 1950 through the late 1960s or early 1970s, and a slight downward trend since then. The decline has exceeded the earlier upswing, leaving the private saving rate since 1982 at the bottom of its usual post-war range. The post-war trend in private saving is followed by both personal and corporate saving, although the decline in corporate saving started in the late 1960s while personal saving remained high until the mid-1970s.

The modest changes in private saving suggest that prospects for change in the future are limited. A more detailed review of past events and policies, however, evidences some potential for change. The pattern of corporate savings is examined first, and then personal saving is explored in greater detail subsequently.

The decline since 1969 in corporate saving relative to net national product can be attributed most directly to the decline in corporate profits as a share of net national product. After all, corporate saving is just the profits that corporations do not pay out in dividends. Corporate profits suffered in the 1970s from inflation and in the 1980s from high real interest rates. Corporate profits had shown a slight downward trend from the late 1940s through the late 1960s in addition to the sharp decline in the 1970s. This longer trend partly reflects a shift in the mix of corporate finance from equity to debt, so that the decline in retained earnings is partly a reflection of decisions to finance more new investment with borrowed funds. The longer trend also reflects a shift toward wage income and a decline in business income. These influences lowering corporate profits have all put downward pressure on retained earnings. Interestingly, corporations have not reduced corporate savings in proportion to the decline in profits, choosing instead to cut dividends disproportionately.

The prospects for corporate saving are unclear. In the near term, corporate profits are projected to recover further as the economic expansion continues, inflation remains moderate, and interest rates fall. Higher profits should raise corporate saving, although higher taxes imposed by the Tax Reform Act of 1986 will absorb some of these projected profits. Over the longer term it is impossible to project with any reliability whether economic conditions will favor corporate profits. Longer run effects of the Tax Reform Act on the debt-equity ratio and the size of the corporate sector are uncertain as well.

Long term changes in the corporate saving rate do not necessarily cause a change in total private saving. Higher interest rates or a shift to greater debt financing transfer capital income from corporations to the individuals who buy bonds and save in financial institutions. These individuals may save as high a proportion of their interst payments as corporations do of their profits. In some cases, trends in corporate saving may just reflect changes in the place individuals choose to save rather than in the level of their saving. In any event, trends in corporate saving need to be considered along with trends in personal saving, and the following section reviews the major influences on personal saving since World War II.

B. INFLUENCES ON PERSONAL SAVING

Personal saving has remained relatively stable in the post-War era in spite of many influences which might have been expected to change it substantially. Chief among these influences are the birth and aging of the baby boom generation, the enrichment of Social Security benefits, the spread of employer pensions and related savings incentives, and changes in the effective rate of return. While none of these influences appears to have had a dramatic effect, some may have had smaller or more subtle influences that portend future changes or carry useful implications for future policies to alter saving. Each of these influences is examined here, along with the influence of recent capital gains. The overriding conclusion is that personal saving cannot be expected to change dramatically in response to policies and events like those in our recent past. Smaller changes are possible, though, due to the aging of the baby boom, and, possibly, in response to policy changes as well.

1. The Baby Boom Generation

The major upsurge in births between World War II and the early 1960s could have had as major an influence on saving as it has had on many other aspects of the economy. In fact, the trends in the personal saving rate since World War II, modest as they are, may reflect the baby boom's effect, and may portend future changes as well.

People tend to save at low rates early in their work years as they start families, and borrow to buy homes, cars, and major durables. Later in their working years people repay debts and begin to accumulate assets for retirement and bequests. By the late 1960s and early 1970s many parents of the baby boom generation had reached the latter halves of their work careers when people begin saving at higher rates. At the same time, many of their children delayed the start of their families. This may account for some of the upswing in personal saving through the early 1970s. Then when the baby-boomers did start families, and made the purchases that this entails, they may have caused the saving rate to fall. Limited evidence for this life-cycle explanation of the trend in personal saving comes from an alternative measure of saving collected by the Federal Reserve Board. This "flow of funds" measure includes the purchase of major comsumer durables as saving, and it has shown less of a decline in personal saving in the last few years, suggesting that part of the recent decline in personal saving is caused by the purchase of major consumer durables.[8]

If the modest trends in personal saving reflect the life-cycle of the baby boom generation, then the saving rate could rise from the late 1980s until the first wave of the baby boom retires beginning in the first decade of the next century. This normal pattern of saving for one's own retirement could fund much of the baby boom's retirement. On the other hand, some observers wonder if the slow earnings growth of the baby boom generation along with their delayed start of families may mean that they will fail to accumulate as much in retirement savings as they will need to maintain their current life style and current retirement ages.

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[8] So long as consumer durables ae considered investments, any decline in measured saving because of their purchase is just a statisical aberration. The purchase of the durable in this case is both saving and investment. For a review of the flow of funds measure of saving see Personal Saving: Not So Low After All, Morgan Economic Quarterly, Sept. 1986, p. 13-16.

2. Social Security

The major expansion of Social Security benefits since World War II might be expected to have reduced personal saving. Social Security, enacted in 1935, paid only small retirement benefits until a series of changes starting in 1950 and continuing through the early 1970s. By today, Social Security benefits replace close to 40 percent of the average worker's pre-retirement income. With this much retirement income provided by Social Security, workers might be thought to reduce their personal saving for retirement. Furthermore, since Social Security has not been funded in advance, any reduced personal saving by individuals would mean lower total saving.

Extensive studies of personal saving in the aggregate and in comparison among individuals have been conducted to determine whether Social Security has led to this expected reduction in personal saving. The studies have been unable to reach any consensus.[9] Apparently Social Security also tends to raise saving and the net effect has not been sorted out. Social Security may have stimulated saving by making earlier retirement possible. The need to supplement the partial replacement of earnings provided by Social Security could have caused people to raise their savings. Another possibility is that persons have kept up their savings in spite of Social Security so they could pass along larger bequests.[10]

3. Employer Pensions

In contrast to Social Security, the spread of advance-funded pensions might be expected to have raised personal saving. Pension assets grew from just over $10 billion in 1950 to almost $1 trillion in 1985 as pensions grew from covering a few thousand employees at the outset in World War II to covering about half of all workers today.

In theory, pensions do not necessarily increase saving because the growth of pension funds could be offset by declines in other personal saving. Individuals might simply shift saving they would otherwise have done to employer plans. Pensions do have special features that could alter workers' savings, but these features could either increase or decrease saving. The tax advantages, which are like those for IRAs, could lead workers to save more because saving is a better deal, or they could lead them to save less because less saving is needed to reach their retirement targets.[11] Aside from the tax advantages, pensions could force additional saving from those disinclined to save. Participation is mandatory for most employees once an employer initiates a plan, and workers without much saving of their own would be unable to offset pension accruals by dissaving other funds. Additional features of pensions, such as early retirement incentives, uncertain benefits, and favorable annuity prices could on net raise or lower worker saving.

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[9] Aaron, Henry J. Economic Effects of Social Security, (Washington, D.C.: The Brookings Institution 1982), p. 40–52.

[10] It seems reasonable that at some point further expansion of Social Security would begin to reduce personal saving but the effect on total saving would depend on any offsetting steps that might be taken with the Federal deficit.

[11] See chapter 9 for an analysis of how tax advantages alter saving.

Detailed studies of wealth and saving by older and higher-paid workers have found that pension participants have greater wealth than their counterparts without pensions. More precisely, these pension participants have been found to have smaller amounts of non-pension wealth and saving, but when their pension wealth is included, the total is higher. Recent studies estimate that for each dollar of pension wealth these workers reduce their non-pension wealth by 60 to 70 cents, leaving their total wealth 30 to 40 cents higher per dollar of pension wealth.[12] Thus, about two-thirds of the growth of pension assets among older and higher-paid workers is being offset by reductions in personally held savings.

Studies have not paid as much attention to younger and lower-paid workers, but pensions could have a significant impact on their saving as well. The 1983 Survey of Consumer Finances has found that over a quarter of U.S. households have less than $3,300 in net worth. The pension participants among these would not have enough other saving to offset mandatory pension saving and, because of low incomes as well as low assets, they could not borrow much either.

The trend in the pension saving rate shown in figure 4.4 suggests that pensions may well have contributed to the modest increase in personal saving through the mid-1970s. However, other influences on personal saving appear to have overwhelmed the effect of pensions since then. The lower line in Figure 4.4 is the saving rate in pensions.[13] The higher line is personal saving rate, which includes pension saving.[14] As the figure shows, the rate of saving in pensions has risen very steadily in the post-war era from 1 percent to 4 percent of net national product. (The downturn in 1983 and 1984 reflected an exceptional downward shift in funding targets due to the decline in interest rates in those years and the rapid escalation of stock prices in 1982.) The upward trend in pension saving is mirrored in the generally upward trend in personal saving through 1974. However, from 1975 through 1983 pension saving continues its upward march while personal saving declines or holds steady. Any increase in personal saving caused by pensions has been offset by other influences since 1975.

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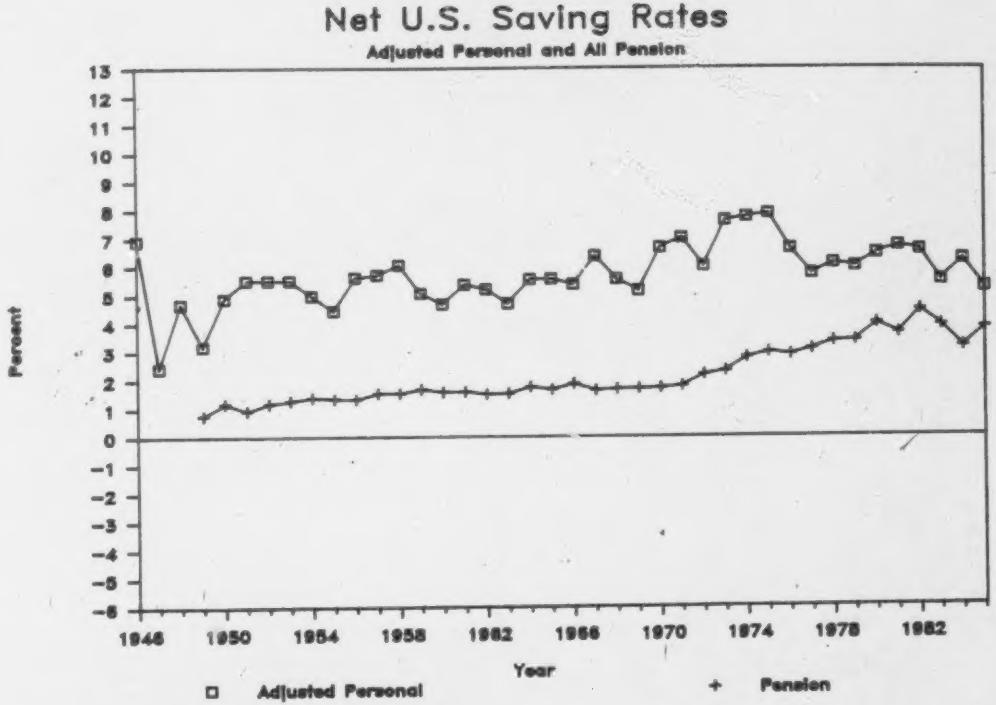
[12] Munnell, Alicia H. The Impact of Public and Private Pension Schemes on Saving and Capital Formation, in International Social Security Association, Conjugating Public and Private: The Case of Pensions (Geneva: ISSA, 1987) p. 230–232. For further discussion see The Congressional Budget Office. Tax Policy for Pensions and Other Retirement Saving, pp. 79–87.

[13] The pension saving rate includes private employer and State and local government pension funds. Pension saving is measured as the chagne in assets of private pension funds, pension accounts held by insurance companies, and State and local government pension funds. These data are taken from the Flow of Funds data compiled by the Board of Governors of the Federal Reserve System.

[14] The NIPA data include pension saving of private employers in personal saving but leave pension saving in State and local government funds in the net budget surplus of State and local governments, as discussed above. In figure 4, the pension saving of State and local governments has been added to personal saving because pension saving is probably viewed the same by workers whether they are publicly or privately employed. Adding the State and local governments' pension fund saving to the NIPA personal saving rate shifts the adjusted personal saving rate in figure 4 above the NIPA personal saving rate shown in figure 3 by the amount of the growing surplus in State and local pension funds shown generally in figure 2. One explanation for the decline in personal saving as measured in the NIPA data is that a portion of personal saving is being shifted to State and local pension funds. Inclusion of that saving in personal saving, as is done in figure 4, lessens slightly the decline in personal saving that has occurred since 1974, but does not change its pattern.

Figure 4.4.



Source: U.S. Department of Commerce National Income and Product Accounts, 1986.

Because pensions have been found to raise saving, an expansion of pensions in the future could be expected to raise saving. Pensions have largely stopped growing however, so further policy changes might be necessary that encourage or require additional pension coverage.[15] While such policies could raise saving by the baby boom generation, they could also encourage the baby boom to retire earlier and expect a higher living standard in retirement. Thus this greater saving might raise the expectations for the baby boom's retirement rather than reduce the burden of supporting it.

4. IRAs and Salary Reduction Agreements

IRAs offer individuals the tax advantages found in employer pensions but not the institutional constraints of those plans. In 1982, when IRAs became available to persons already participating in a pension, contributions to IRAs mushroomed. Two initial evaluations of IRAs have concluded that IRAs do increase saving.[16] However, in both cases the saving increase was found to be independent of a contributor's tax rate, which suggests that the tax incentive may not have been the primary motivation to save. The authors of the studies speculate that the strong advertising for IRAs by financial institutions in 1982 and 1983 may have spurred many to contribute who would not normally have done so. If advertising was the primary cause, the incentive itself may not have as large a long-term effect. Further study is needed to determine the long-term saving effect and validate the short-term effects found in the initial studies. The limitations on deducting IRA contributions imposed in the Tax Reduction Act of 1986 will lessen any impact IRAs have had on saving.

Salary reduction arrangements, most commonly in the form of 401(k) plans occupy an intermediate position between pensions and IRAs. Contributions are voluntary as with IRAs, but employers who sponsor plans are constrained to ensure that contributions by the highly compensated do not exceed those of other employees under the plan by more than specified amounts. As a result, employers often make matching contributions to elicit greater contributions from the non-highly compensated than such workers normally would make. Salary reduction plans are too new for their effect on savings to have been quantified; however, they do seem to be more successful than IRAs at securing contributions from younger and lower paid employees.[17] Still, their effect on saving may fall short of that for traditional pensions which have mandatory participation rules. In fact, if IRAs and salary reduction plans spread at the expense of traditional employer pensions, saving might be reduced.[18]

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[15] See chapter 9 for further discussion of current pension coverage and future prospects.

[16] The two studies were both conducted by Steven F. Venti and David A. Wise and released as working papers from the National Bureau of Economic Research, Cambridge, MA. The first is IRAs and Savings, Working Paper No. 1879, April 1986. It found that the contribution would come 50 percent from increased saving, 35 percent from reduced taxes, and 15 percent from the shifting of liquid assets to IRAs. The second study is Have IRAs Increased U.S. Saving?: Evidence from the Consumer Expenditure Survey, Working Paper No. 2217, April 1987. It uses alternative data and reaches the same general conclusion.

[17] U.S. Congressional Budget Office. The Tax Advantage of Pensions and Other Retirement Saving, 1986, p. 63.

5. General Changes in the Rate of Return on Saving

Changes in inflation, interest rates, and tax rates change the effective rate of return[19] for nearly all personal and corporate saving. Such changes, therefore, could affect the level of nearly all private saving in the same way that the tax advantages for qualified employer plans and IRAs affect retirement saving. As noted in the discussion of IRAs, however, changes in the rate of return have an uncertain effect on saving. The uncertain effect is illustrated by events since the 1970s. The personal saving rate has declined from the mid-1970s through 1985 in spite of big swings in the effective interest rate. First, the effective interest rate declined during the 1970s as inflation both rose faster than interest rates and pushed persons into higher tax brackets. Then in 1982, the effective interest rate rose to a post-war high and has remained historically high since. The increase resulted from declining inflation, high interest rates relative to growth in net national product, and tax rate reductions enacted in 1981. The continued decline in the personal saving rate during these swings in the effective return shows the difficulty of establishing any link between the rate of return and saving, and also suggests that if a link exists, it is not of overwhelming importance. The difficulty of finding any relation between saving and the rate of return, as illustrated here, has been found in repeated econometric studies as well. The general conclusion is that existing data are inadequate to support a definitive finding.[20]

6. Capital Gains

The decline in personal saving since the mid 1970s has been attributed by some to capital gains on existing assets. House values rose rapidly in the 1970s and stock prices have risen rapidly since 1982. If these increases made people feel wealthier, they would have less need to save and more reason to increase current consumption. This could account for some of the decline in the personal saving rate since 1974. However, the reasoning is somewhat limited because stock prices fell dramatically in the 1970s while house prices were rising, and then house prices stayed steady or declined in the early 1980s while stock prices soared. Even when capital gains is included as saving, the saving rate in the 1980s is below rates of earlier decades, although saving is up in the late 1970s.[21]

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[18] Salary reduction plans are spreading rapidly. Over one-quarter of the employees at medium and large employers were offered 401(k) plans in 1985 and in 1987 the Federal Government is extending salary reduction to its 3 million civilian employees. Salary reduction is also allowed for non-profit and for public sector employees.

[19] The effective rate of return means the after-tax rate of return in dollars of constant purchasing power.

[20] See for example, King, Mervyn. The Economics of Saving: A Survey of Recent Contributions. [In] Arrow, Kenneth J. and Seppo Honkapohja, eds. Frontiers of Economics. Basil Blackwell (Oxford: 1986), p. 271–276. For a less technical discussion see McLure, Charles E. Jr. Taxes, Saving, and Welfare: Theory and Evidence. National Tax Journal, Sept. 1980. p. 311–320.

[21] Poterba and Summers, Recent Evidence. . . . p. 8 and table. 2

C. OVERVIEW OF SAVING

The U.S. saving rate rises and falls sharply with increases and decreases in the Federal deficit. Throughout most of the post-war period these fluctuations have been short lived, reflecting the effect of the business cycle on Federal revenues. However, the surge in Federal deficits since 1982 has persisted through the recovery and is causing a longer-term lowering of the U.S. saving rate. Private saving has been comparatively stable since World War II but a decline since the mid 1970s is aggravating the decline caused by growing Federal deficits. The relative stability of personal saving has persisted in spite of the birth and growing up of the baby boom generation, the enrichment of Social Security benefits, the spread of employer pensions and IRAs, and swings in inflation, interest rates, and tax rates. While none of these events has caused major changes in personal saving, the baby boom generation, pensions, and changes in the effective rate of return may have had modest influences on the saving rate. Future saving appears most likely to be increased by reductions in the Federal deficit. The aging of the baby boom may also raise future saving modestly. Policies to increase saving will probably have only small effects, and some, such as expanded pension coverage, could raise expectations for retirement living standards as much as they reduce the burden of providing for existing standards and for future generations. Stable economic growth would probably contribute most to increased saving through the corporate sector.

III. POLICY IMPLICATIONS

Of key significance regarding the way social security is structured to pay for the retirement of the baby boom is its relationship to Government finance. Because they are invested in Government securities, the social security trust funds hold part of the national debt. Although attention on the national debt usually focuses on debt held externally to the Government, the debt actually has two components: one consisting of obligations owed to private parties and other non-Federal entities—what might be referred to as external debt or debt held by the public—and another consisting of obligations owed to various Federal agencies and trust funds, such as social security's.

When social security takes in more income than it needs to meet its immediate expenses, the new Federal securities purchased with the excess income are credited to the social security trust funds and become part of the federally held portion of the debt. Thus, to the extent the trust funds rise, the national debt also rises. In exchange for the promise to redeem the securities held by the trust funds at a future time, the Treasury has the use of the revenues raised by the excess payroll taxes. Conversely, when social security spends more than it takes in, the Treasury cashes in some of the securities held by the trust funds. In effect, it repays the loans it received so that social security can meet its immediate expenses. If the Government does not reduce spending on other programs to offset the value of the cashed-in securities, then it must raise revenue through other forms of taxes or sell new Government securities in the financial markets, in order to raise the funds to cash in the securities redeemed by the trust fund. The cashed-in securities are then no longer a part of the national debt.

This arrangement illustrates that although in a formal sense social security income cannot be used for other governmental functions, in certain circumstances it can have that effect. This occurs when payroll tax receipts exceed program expenditures and the Government uses these funds to increase spending or reduce taxes (from what they otherwise would be), or to reduce borrowing from the public that otherwise would take place. In the latter circumstance debt held by the Government would replace debt that otherwise would be held by the public (other things being equal, the total national debt would not change).

The actual use of surplus OASDI funds basically depends on federal budgetary policy. If the budget, which after FY 1985 no longer includes OASDI, were in deficit, the surplus OASDI tax receipts essentially would be used to help finance the deficit (replacing additional borrowing from the public that otherwise would take place). If the excess OASDI tax receipts were greater than the budget deficit, or the budget were balanced or in surplus, the Treasury could use these funds to reduce (or "retire") the amount of the national debt held by the public.

If borrowing from the public were reduced, more of the public's savings would be available for alternative investments. Presumably private investors instead of purchasing or holding public debt would make investments in private enterprises, in this country or abroad, over and above what they would have otherwise. This would allow a higher long-term growth in private capital stock, and, assuming the investments are productive, greater future levels of output, income and consumption. Thus, if the trust fund build-up did result in a reduction of borrowing from the public, national savings[6] would increase, which in theory would lead to increased productive capacity. Indeed, it has been said that "the likely net result of this trust fund buildup will be an increase in national savings and capital formation . . . . As a result of the surpluses then, future generations will have a relatively higher standard of living from which to contribute taxes to redeem the debt when the time comes to pay future benefits."[7]

It is not clear, however, that the trust fund buildup will necessarily lead to increased aggregate savings and capital formation. First, it is impossible to say to what use the excess social security taxes will be put in the coming decades—i.e., whether they will cause less borrowing from other sources, higher spending, or lower taxes than would otherwise occur—or some combination of these effects. If the excess social security taxes were spent on other Government programs or used as a substitute for other forms of taxes, Federal borrowing from the public would not be lowered, and there would be therefore no favorable effect on national savings.[8] Several considerations make this plausible. First, even under the conditions specified by the II-B assumptions, the projected surpluses may never materialize. For example, a potential drain on these projected surpluses may be the Hospital Insurance (HI) part of medicare, which, while highly volatile, is projected under the same II-B assumptions to run a deficit of .44 percent of payroll over the next 25 years and 2.59 percent of payroll from 2012 to 2036. As HI is funded from the payroll tax, and Congress has shifted resources among the OASI, DI, and HI trust funds in the past, it is possible that OASDI surplus funds may be used to shore up HI.[9]

Also, to posit that the social security surplus will result in increased national savings presumes that they will be "set aside" in budget considerations. This outcome may be unlikely if, as they have been for the past 20 years, fiscal decisions continue to be based on a unified budget basis, i.e., including social security. In this regard, it is highly significant that the Gramm-Rudman-Hollings (GRH) deficit reduction measure, while taking social security "off-budget" beginning in FY 1986, nevertheless includes social security's income and outgo to meet the GRH deficit targets. As recognition grows that the true economic impact of Government deficits is measured more by their effect on borrowing from the public rather than by the balance sheet of the general fund, and that such borrowing is directly affected by social security's surpluses or deficits, fiscal policymaking may in fact continue to be made on a unified budget basis.

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[6] In economic terms, the reduction in Federal borrowing would represent net savings by the Government.

[7] Munnell, Alicia H., and Lynn E. Blais. Do We Want Large Social Security Surpluses? New England Economic Review, September/October 1984. p. 14–15.

[8] If the excess social security taxes led to increased spending on Government programs, the nature of the programs may have different effects on the level of national wealth. For example, greater spending on public investments such as education or infrastructure could pay off later in increased productivity and wealth, whereas spending on programs that serve merely to raise current living standards probably would not.

[9] On the other hand, the use of excess social security taxes to help cover costs in the HI program should not necessarily be considered inevitable. Recently, the long-range picture for the HI trust fund has been improving. Four years ago, it was projected to become insolvent by the end of this decade. Now, for a variety of reasons, including cost containment measures enacted by Congress, that insolvency is not projected to occur until after the turn of the century. Continuing concern about the size of the health sector of the economy, and the growing share of the gross national product that it represents, may lead to further measures to restrain Federal health expenditures.

Furthermore, even if more economic growth occurred because these excess receipts led to increased savings and capital formation, when the baby-boom retires the Government would still have to obtain resources from the economy in order to redeem the securities held by the trust fund. Redemption of the Government bonds would require higher taxes, less spending on other programs, or greater borrowing from the public—just as would be required if social security were tacitly financed on a pure pay-as-you-go arrangement. The question is, how should this "burden" on succeeding generations be characterized?

It may be helpful to distinguish two elements of the various concepts of "burden" that often seem to arise in discussions of the impact of the baby boom. One is the sense of dependency, and in the context of the baby-boom's retirement, it is clear that regardless of the means used to finance their social security benefits, retirees basically will be dependent on the output of workers. Another synonym for burden, though, is "imposition," a sense of onerous, even oppressive obligation, that impedes or hinders. In this regard, the question of whether the baby boom is a "burden" on succeeding generations concerns issues of equity and fairness. This distinction between burden as dependency and burden as onerousness can be crucial in discussing the nature of the claims the baby boom will have on the future economy.

For example, from the fairness point of view, it is posited that, if the baby boom added to the productive capacity of the economy through investment generated by their savings, they would not impose a "burden" on society when they retire because the increase in output attributable to that savings would pay for their retirment income. In other words, the workers supporting the baby-boom's retirement should not complain because they would be in the same position they would have been in if the baby boom both had not contributed to national savings during their working years and did not draw retirement benefits.[10] Similarly, to the extent that national savings resulted from an increase in U.S.-owned foreign assets over these 30 years, the cashing-in of such assets (by using them to pay for imports) during the baby boom's retirement might allow succeeding generations to feel less of a "burden" because part of the burden would have been felt earlier—when the United States sent its exports abroad to acquire the foreign assets. (See chapter 4.)

From the dependency point of view, however, the wrench produced by a large segment of the population changing from producers to consumers would in fact be viewed as a "burden." Reaching a consensus on how to garner the necessary resources to make the promised benefit payments would remain a political problem. Those who must do the producing—those who follow the baby boomers—may be unimpressed to be told that they can more easily do so because national savings have risen for 30 years, and therefore that they can bear the "burden" more easily because they are better off than they would have been. While the concept of the baby boom saving for their retirement may describe economic reality, future workers may feel frustrated if they fail to achieve their income expectations because of the high levels of economic resources needed to meet the consumption needs of the generation that preceded them. However unwarranted, the workers of that period could perceive the change in their disposable income as a reduction in their standard of living.[11]

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[10] Aaron, Henry, J. When is a Burden Not a Burden? The Elderly in America. The Brookings Review, Summer 1986. P. 19-20. Mr. Aaron acknowledges that this perspective depends on the existence of effective instruments to control the national savings rate.

The degree of this perception may depend in some measure on how they view relative versus absolute changes in their standard of living. While their economic position may have been enhanced over the years in regard to what they can purchase compared to what previous generations could purchase, they may be more concerned that their standard of living is lower than they believe it otherwise would have been were it not for the demand imposed on their labors because of the retirement of the baby boom.

Also, the fact would remain that regardless of whether social security acquires a "surplus" of Government IOUs, benefits in the future will have to be furnished predominantly by the Nation's production of goods and services at that time.[12] The Government will be extracting relatively greater resources from the economy in order to sustain the consumption needs of a disproportionately large non-producing segment of society. What the Nation will consume 30 years from now cannot, for the most part, be stockpiled. Economic growth and technological advances in the meantime may enhance the Nation's productive capacity, but that growth may not change the significant, and potentially wrenching, effect of a large part of the population changing from producers to retired consumers. Medical care, transportation, food and other perishable goods and many other services that the then-retired segments of society previously helped provide really cannot be "stored" in advance.[13] On the other hand, investments such as skills inculcated to an engineering student in the year 2000 do represent stored services available in 2030, and so would U.S. holdings of foreign assets.

In regard to social security, economic growth should not be viewed as the sole solution to any potential problems arising from the baby-boom's retirement. Because social security is basically an indexed system, economic growth to a certain extent leads to higher absolute (not relative) costs. This occurs because benefits are tied to average wage levels. If economic growth is reflected in higher wage levels, this will eventually lead to higher benefit levels, and thus higher costs (measured in absolute terms). In other words, the system has a self-adjusting element to it. Put another way, if society grows wealthier and this increase in wealth leads to higher social security benefits, would not the "burden" remain approximately the same, even if the Nation's economic base were expanded? This point of view has some validity and does have a bearing on the argument about whether the Nation can "outgrow" any potential problems in the baby-boom's retirement. However, as illustrated later, higher wage-growth does lower the system's relative costs as measured against the Nation's taxable payroll. (The primary reason this occurs is because of the lag between the increase in taxes paid on the higher earnings and the payment of benefits based on these earnings.)

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[11] Koitz, David S. [Forthcoming paper on the social security surplus.]

[12] (Supplemented by the drawdown of capital and inventories, and perhaps by net imports, as when Federal debt is purchased by foreigners.)

[13] Koitz.

The key consideration is that social security cannot be regarded as a fixed cost whose importance can be proportionately lessened by simply expanding economic growth. To a certain extent, social security will grow as the economy grows, and thus economic growth alone will probably not substantially change the effect of the retirement of the baby boom on social security.

Social security's effect on Government finance begets other issues. Because social security's projected surpluses can lower Federal Government borrowing from the public, in the present budgetary environment they can lower pressure to cut other programs or to increase other Government revenues.

In the 1990s, as the surpluses really begin to mount, they may have the effect of hiding the true cost of other Government programs, or they may permit expansion of Government programs or curtailment of efforts to contract them. It is troubling to some analysts that the functioning of Government could come to rely so heavily on the payroll tax, which they feel is regressive. Indirectly, lower-paid people, who it is alleged have borne the brunt of cuts in Federal social spending, would be paying heavily to finance Government, and their doing so would help keep more progressive levies from being increased. From another perspective, however, the mounting surpluses of the social security funds pose a different problem. If the accumulation of surpluses drains purchasing power from the economy, a case can be made that unless a deficit is run on other Federal accounts, the Federal sector may exert too much drag on demand and help cause recessions or worse. This point of view was expressed by a Washington Post editorial of September 5, 1986: "As social security is currently set up, it is necessary to run large deficits in the general fund for the rest of the century, or social security will choke off growth."

In any event, if the surpluses were used to reduce other taxes, increase spending on other programs, or reduce borrowing, this might lead to long-term expectations of Government services that would probably be deflated when the baby boom retires. For example, people might come to expect more from the Government for a given amount of other (non-social security) taxes. Later, when excess social security taxes were no longer available, that level of Government service could be maintained only by raising those other taxes. In other words, the "advance" funding of social security might foster new forms of demands upon the Government. This scenario could lead to additional taxes being levied on future workers: to pay for higher social security outlays, and to pay for Government activities that formerly were financed from excess social security taxes.[14]

Even if excess social security taxes did lead to national wealth that would not otherwise exist, these questions persist. With all these ramifications, one may ask why such surpluses should be accumulated. Why not create a future schedule that would match the system's immediate costs? Are not the practical consequences, for the Government as a whole, the same? In effect, it could be averred that the program will be financed on a de facto pay-as-you-go basis anyway, so why not make it explicit?[15]

Explicit pay-as-you-go financing would not alter (but would make more evident) the growing dependence on future workers to meet the benefit commitments to the baby-boom and later generations, and hence would not directly address the long-range political and economic questions that arise therefrom. However, pay-as-you-go financing would address several concerns regarding the potential social security surplus. Some analysts are uncomfortable with the possibility of social security potentially holding virtually all the national debt. They warn that this could disrupt traditional methods of Government finance; for example, if the Federal Reserve could not sell Government securities to banks and private parties (open market operations), the ability to use monetary policy for economic stabilization and growth would be limited.[16] Pay-as-you-go financing would also alleviate the concern that the surpluses might be used, not to increase capital formation and economic growth, but instead to offset deficits elsewhere in the budget, which would cause general Government expenditures for the next 30 years or so to be financed by the relatively regressive payroll tax rather than the more progressive income tax.[17]

Even if the surplus should lead to increased national savings, capital formation, and economic growth, there is debate about whether the payroll tax is the appropriate means to promote such growth. The issues involved are mostly ones of equity. Henry Aaron, an economist at the Brookings Institution, has expressed these concerns:

> If our objective is to increase the rate of capital accumulation, we should ask which instruments are best for achieving that end. Prominent on the list would be direct assaults on the federal deficits, incentives to business investment, and the withdrawal of incentives that promise inefficient investments.
>
> * * * If one turns to other instruments such as a reduction in the government deficit to increase national saving, it might be argued that creating a large surplus in the social security trust funds is a good way to achieve one's goal.
>
> The question that this suggestion raises is whether reductions in social security benefits or increases in the payroll tax are the ways to achieve a reduction in the

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[14] Ibid.

[15] The accumulation of the large reserve is not really a deliberate goal. Congress over the years has generally adhered to the recommendation of several Social Security Advisory Councils that the trust funds build up a reserve sufficient only to allow the system to weather economic downturns. In 1972, when Congress enacted large benefit increases and introduced automatic indexing for wages and benefits, it scheduled a tax hike in 2011 to cover the increased costs of the baby boom's retirement and keep the system in actuarial balance. As long-range projections worsened, Congress accelerated the 2011 increase, first to 1990 and then to 1988. These changes were chosen as a means of reassuring the Nation that the system was solvent in the long run; the accumulation of surpluses was of secondary concern.

[16] Munnell, Social Security Surpluses, p. 17. It is not clear, however, why Federal open-market operations could not be conducted with any financial security and have the same effect on the money supply.

[17] Ibid., p. 16.

> government deficit that are most conducive to economic efficiency and fairness. Why should benefit reductions or payroll tax increases, rather than increases in other taxes or reductions in other government spending, be used as the instrument to raise total savings?
>
> * * * If we wish to increase capital formation, the proper objective is the total saving rate, and that raising social security payroll taxes or cutting social security benefits is a poor device for achieving that objective unless we favor them on other grounds. We should make social security policy on the basis of considerations other than its supposed effects on saving.[18]

There is another perspective on equity, however, and it has to do with perceptions of fairness *within* the Nation's retirement system. In the social security system true pay-as-you-go financing would likely raise broad questions of generational equity. Sometimes the question is put in terms of the baby boom's paying its way by storing up funds for later use. As discussed above, this is not really meaningful because of the way social security affects Government financing. However, if one accepts that the social security surplus would be used for capital formation and an increase in the Nation's productive capacity, then "the projected trust fund accumulation may be viewed as an attempt to avoid an excessive tax burden on future generations after the first quarter of the next century." [19]

If one views the incidence of the social security tax as regressive, the roller-coaster effect on tax rates of pay-as-you-go financing raises large distribution questions. The Federal Government must extract resources from the economy at the time of the baby boom's retirement irrespective of whether there is a large trust fund, but the form of that extraction could be different if the method used were to increase the payroll tax rapidly. In terms of distributional equity, the question is whether it is better to spread a "regressive" tax evenly across the generations, or to allow the baby boom to pay taxes equivalent to 9.94 percent of taxable payroll while succeeding generations would pay at rates as high as 16.06 percent (under the II-B assumptions.) Although the current arrangement may be viewed as not substantially different from true pay-as-you-go, under it the benefit costs arising in the next century, ostensibly financed out of social security reserves, would be met by less regressive means.

A. RATES OF RETURN: THE RELATIONSHIP OF TAXES AND BENEFITS FOR FUTURE BENEFICIARIES

Another matter of equity between the generations concerns the rate of return, or "money's worth" that workers receive from social security for their payroll taxes. Today's retirees on average receive more, often far more, than the value of the social security taxes they have paid. This is true whether or not contentious factors such as interest or the employer's share are included in assessing the value of accumulated taxes.

It has been stated that those retiring recently receive benefits that are about three times as large as the sum of their employee and employer taxes, assuming the taxes were invested and earned a real (i.e., above inflation) interest rate of three percent. Projections show that future recipients will get a much worse "deal" from the program.[20]

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[18] Aaron, Henry J. Economic Effects of Social Security. Washington, The Brookings Institution, 1982. p. 51-52.

[19] U.S. General Accounting Office. Social Security Past Projections and Future Financing Concerns. March 1986. p. 65.

Analysis by the Congressional Research Service looks at this issue a different way, comparing the amount of time it takes retirees, now and in the future, to recover the value of their social security taxes plus interest under the II–B assumptions. For example, a worker retiring at age 65 in January 1987, after having always earned an average wage in covered employment beginning at age 21, would recover the value of his and his employer's OASI taxes plus interest in 9.8 years. This compares to a life expectancy of 14.7 years (men) and 18.9 years (women) under the II–B assumptions. For a similar worker retiring at age 65 in 2000, however, it would take 15.4 years to recover the value of taxes plus interest. This compares to a life expectancy of 15.6 years (men) and 20.1 years (women). In the year 2040, the recovery time becomes 19.3 years compared to a life expectancy of 17.0 years (men) and 21.9 years (women).[21]

Defenders of social security tend to discount this phenomenon, arguing that the program serves social ends that transcend calculations of which individuals, or generations, obtain some sort of balance-sheet profit or loss. They point out that basically pay-as-you-go systems such as social security by their nature provide large returns on the contributions of the initial generations. In the early years of such programs, the ratio of workers to recipients is very high, allowing tax rates to be low. As the program matures, tax rates rise to reflect the increase in the number of beneficiaries. This is not unique to social security. Establishing benefit levels for early recipients in excess of what contributions would dictate is also found in private pension systems.

Furthermore, proponents argue that providing "adequate" benefits to initial recipients that were essentially "unearned" in relation to their contributions to the system was a deliberate social policy. Providing a minimum level of protection to the first workers to participate in the system was considered more important, in a period of economic depression, than concerns about excessive rates of return on taxes paid. Besides, the social benefits of giving a measure of economic independence for the elderly, and later for orphaned children, surviving spouses, and the disabled, are valued highly. For example, younger workers are in large part relieved from the financial burden of supporting their parents, and the elderly are afforded an opportunity to live independently and with dignity.

Critics point to these social welfare features as a basic flaw in the program that creates inequities. They say that one of these inequities is that future beneficiaries will on the whole receive benefits inferior to those that the equivalence of their taxes could purchase in the private sector. Furthermore, it is averred that if interest is included, some categories of workers will not even recoup in purchasing power what they and their employer paid in taxes. Often buttressing these arguments are calculations that show what individuals could receive if their social security taxes were invested privately.

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[20] Boskin, Michael J., Lawrence J. Kotlikoff, Douglas J. Puffert, and John B. Shoven. Social Security: A Financial Appraisal Across and Within Generations. Working paper no. 1891. Cambridge, Mass., National Bureau of Economic Research, Inc., 1986. p. 4.

[21] These calculations do not take account of the taxation of social security benefits, which will increase in the future because the thresholds beyond which social security becomes partially taxable are not indexed to take into account expected increases in the income of future retirees. Although the social security benefits is still paid in full, the provision may be regarded as a reduction in benefits. A reduction of benefits, of course, increases the period over which it takes to recover social security taxes. Because the taxation of benefits affects future beneficiaries more, it can exacerbate perceptions of intergenerational inequity.

Such calculations can vary tremendously depending on the assumptions and methods used. They may or may not include the employer's share of the payroll tax or assign a value to survivor benefits. They also are very sensitive to interest rate assumptions. Regardless of the methods or assumptions used, the perception of intergenerational inequity is heightened by such calculations.

A different picture would emerge, however, if social security were placed on a true pay-as-you-go basis, that is, if surpluses were not accumulated. If each year's income were made approximately equal to outgo, OASDI tax rates would decline to about 4.8 percent on employees and employers, each, by 2005 but rise to about 7.7 percent by 2035. Such variations in taxes would produce significant swings in the relationship of taxes versus benefits, depending on one's age cohort.

The generations following the baby boom would be at a particular disadvantage. Their rates of return on their social security taxes, already low because the system would be fully mature, would be lowered further because of the higher social security taxes they would pay under this arrangement. Under current law and the II-B assumptions, a baby boomer born, say, in 1955, and a future worker born in 1995, both of whom always earned the average wage and retired at age 65 would recover the value of their and their employer's OASI taxes in approximately the same amount of time.[22] Under pay-as-you-go financing, however, the recovery times become 17.4 and 24.8 years, respectively.[23]

TABLE 8.6.—NUMBER OF YEARS TO RECOVER COMBINED EMPLOYEE-EMPLOYER OASI TAXES PLUS INTEREST FOR AGE 65 WORKERS RETIRING NOW AND IN THE FUTURE UNDER THE II-B ASSUMPTIONS [1]

	Minimum earner (years)	Average earner (years)	Maximum earner (years)
Illustration 1: Current law:			
Year of retirement:			
1987	7.2	9.8	12.2
2000	10.8	15.4	20.8
2020	13.1	19.5	31.3
2040	12.5	19.3	32.5
2060	12.4	19.3	32.4

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[22] 19.5 and 19.3 years, respectively. The slight difference is mainly due to high real interest rates in the 1980's.

[23] One can argue that viewing recovery times on a true pay-as-you-go basis is really a more accurate way to assess intergenerational equity in regard to the relationship of social security taxes and benefits, because the accumulation of social security surpluses masks the true demand on the nation's resources that social security benefits for the baby boom will cause.

TABLE 8.6.—NUMBER OF YEARS TO RECOVER COMBINED EMPLOYEE-EMPLOYER OASI TAXES PLUS INTEREST FOR AGE 65 WORKERS RETIRING NOW AND IN THE FUTURE UNDER THE II-B ASSUMPTIONS [1]—Continued

	Minimum earner (years)	Average earner (years)	Maximum earner (years)
Illustration 2: Pay-As-You-Go:			
Year of retirement:			
2020	11.9	17.4	27.4
2060	15.7	24.8	43.7

[1] Taking into account projected cost-of-living-adjustments and continued accrual of interest after retirement.

Source: Congressional Research Service.

B. INTERGENERATIONAL EQUITY AND WEALTH

Discussions of intergenerational equity usually evolve to a central question, pertinent to social security as well as to other areas that compare the well-being among age cohorts. What degree of affluence do we expect society to have in the future? In one assumes that future generations will be wealthier, a view consistent with long-term historical trends, then one can plausibly argue that it is wrong to over-tax current workers to accumulate surpluses (or more accurately, to force the baby-boom generation to save more to promote investment and economic growth) because the generations that follow, being wealthier, can and should afford to pay for the baby-boom's benefits.

There is another school of thought, though, that is concerned that "We may be the first society in history of which it can be said that children are worse off than their parents." [24] It has been expressed that "In the new America, the old are being enriched at the expense of the young, the present is being financed from tax money expropriated from the future and one of the legacies children appear to be inheriting from their parents is a diminished standard of living." [25] If current over-consumption is eating the seed-corn of future generations, in other words, these generations may not be much wealthier, and not able to bear the burden of the baby boom's retirement easily.

While these views may be irresolvable, in regard to social security their effects are quantifiable. Financing of social security is predicated on the system being in actuarial balance, and under the II-B projections it is. These projections assume real wage growth in the future (leveling out at 1.5 percent a year in the next century), a reflection of projected productivity increases and a steadily rising standard of living. In other words, the II-B projections do assume that society will be wealthier on a per capita basis. What is more, if this increase in the standard of living does not occur, the system will be under-financed. For example, if long-term real wage growth were less, say 1.0 percent rather than 1.5 percent, the actuarial balance would drop by 0.81 percent of payroll, meaning that benefit cuts or payroll tax increases would have to be put in place over the next 75 years to restore the program to the financial position it is projected to be in today.[26] This obviously would affect calculations of measures of intergenerational equity.

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[24] Senator Daniel P. Moynihan, as quoted by Paul Taylor. The Coming Conflict As We Soak the Young To Enrich the Old. Washington Post, Jan. 5, 1986. p. D1.

[25] Taylor. p. D1.

What this means is that wealth, at least in the form of increased wages, has to grow in the future in order to make meaningful comparisons of equity under current-law benefit and tax rates. If the growth in wealth does not occur, intergenerational equity considerations in regard to social security will probably become secondary to solving persistent long-term fiscal crises. (Depending on how these crises are solved, however, problems in intergenerational equity may be exacerbated.)

IV. POLICY OPTIONS

If Government retirement income programs, regardless of whether they use pay-as-you-go or partial advance funding, place the Government in the position of having to impose additional taxes in one form or another on future workers or to reduce other Government programs, more reliance on private means might be explored to relieve this potential problem. To the extent that private sources of retirement income were substituted for part of social security in the future, the need to increase taxation (or reduce benefits or other Government spending) could be lessened.[27]

It is sometimes argued that substituting private retirement savings for social security taxes would promote greater economic growth. This would, in theory, provide a greater economic base to draw upon later to pay for the baby boom's retirement benefits. However, a reduction in payroll taxes alone does not guarantee that private retirement savings will increase, i.e., the tax reduction could be consumed. If a mechanism were used to ensure that equivalent funds were invested privately rather than paid to the Government in taxes, it still would not necessarily result in increased economic growth—it depends upon how the money is used. This would assume that those private sources were fully funded in wise investments, and not allowed to be drawn down for preretirement consumption. As mentioned before, it has also been suggested that the Government could use excess social security taxes to raise savings and promote economic growth.[28]

This discussion is part of a broader debate about the most effective means to stimulate economic growth. What is pertinent in this analysis is the conclusion that replacing part of social security's role by private retirement savings still raises the same question: What are the economic ramifications of having fewer producers for each retiree? Even if private investment of what would otherwise be social security taxes resulted in greater economic growth, the draw on society to meet the consumption needs of the retired baby-boomers and later generations might not be essentially different.

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[26] 1987 OASDI Trustees' Report, p. 98.

[27] There have been several suggestions on how to do this. One way is to reduce social security's role by indexing future benefits to the change in prices rather than wages. As wages are projected to grow faster than prices, future replacement rates would decline rather than be constant as in current law. This would cause social security's costs to drop and in theory make more room for private sources of retirement income. Other proposals would (1) allow workers to forego part of their future social security benefits by contributing instead to private instruments such as IRAs, and (2) modify the social security program to pay welfare-related or annuity benefits only. Increased taxation of social security benefits could also be used to reduce payroll taxes, and could be supported by some as an indirect way to better align benefits with need.

[28] Koitz.

The magnitude of the effect of the aging of America may depend heavily on future attitude concerning retirement. Future generations are assumed to retire at about the same ages that people do today. They are expected to live longer, but they are not expected to work longer, even though the age for full retirement benefits rises to 67 by 2027, and the delayed retirement credit and the earnings test will be liberalized in the 1990s.[29] A possible policy response in this area might be to raise the retirement age further. This might be justified not only as a way to reduce the costs of social security, but also as a way to bring the time spent in retirement for future beneficiaries closer to what was envisioned at the time of the original Social Security Act. For example, a male retiring at age 65 in 1940, the first year in which social security benefits were payable, had a further life expectancy of 11.9 years. A male retiring at age 65 in 2020 is predicted to have a further life expectancy of 16.3 years. (The figures for females are 13.4 years and 21.0 years, respectively.)[30] As the raising of the full retirement age to age 67 is not predicted to increase significantly the age at which people retire, it probably would be more effective to raise the age at which reduced retirement benefits can be taken. Alternatively, the amount of the reduction for early retirement could be increased.

Weighed against such proposals must be considerations that not everyone may be likely to benefit from improvements in longevity. Certain people may not be able to work longer because they are in poor health. Others may be unable to locate work after losing their jobs late in life. In other words, there may be people who, through no fault of their own, may be unable to find an alternative source of income to make up for lower social security benefits. From one point of view, such people should not be penalized for the longevity of others.

Related to the issue of the elderly's inability to adjust to changing circumstances is the problem of the "old old." As highlighted in chapter II, the proportion of people over age 80 is projected to increase rapidly in the future. These people might remain on the social security rolls for many years. Their social security benefits would be fully adjusted for inflation, but other sources of income might not. Indeed, income from assets might be fully exhausted. Moreover, not only might their real income decline during retirement, their living expenses might grow because of rising health care costs associated with aging. Even if the purchasing power of benefits were maintained, after a long period of time a beneficiary's standard of living would, under the II–B projections, fall significantly behind that of workers retiring then. It was these considerations that led the 1979 Advisory Council on Social Security to contemplate recommending that those over age 85 receive a social security supplement (a one-time benefit increase of 10 percent). The Council ultimately rejected this proposal, however, because it was not tightly targeted to real need, and in many cases the problem could be more appropriately addressed by welfare programs.

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[29] The full retirement age (the age at which one receives unreduced benefits) will rise gradually from age 65 to age 66 over the period 2003 to 2009, and will rise again to age 67 from 2021 to 2027. Benefits will still be available as early as age 62, but the actuarial reduction will increase (benefits taken at age 62 eventually will be 70 percent of those taken at age 67, whereas today they are 80 percent of those taken at age 65).

The delayed retirement credit (DRC), which is a increase in benefits given to those who retire later than the full retirement age, currently is equal to ¼ of one percent for each month (3 percent a year) beyond the full retirement age that a person does not receive benefits. The DRC will increase gradually to ⅔ percent per month over the period 1990 to 2008.

The earnings test currently withholds one dollar in benefits for every two dollars a beneficiary earns from work above certain threshold amounts. For those attaining the full retirement age in 1990 and later, one dollar in benefits will be withheld for every three dollars in earnings above the exempt amount.

[30] 1987 OASDI Trustees' Report, intermediate II-B forecast, p. 36.

Other possible policy options in the area of benefit adjustments could include an examination of the social security benefit formula. For example, if there is concern that pension coverage will remain inadequate for lower-paid workers in the future, some may advocate that the weighting of the formula be increased to narrow the gap in overall retirement income between lower- and higher-paid workers. On the other hand, there may be pressure to increase replacement rates for higher-paid workers, because their lower rates of return on taxes paid are the ones most often cited as to why social security is a "bad deal." Whichever way the formula is adjusted, if the change is not "cost-neutral," the program's actuarial balance will be affected, with the ramifications on intergenerational equity discussed previously. A zero-sum game occurs if it is cost-neutral, as increases for one group come at the expense of another.

Benefit computations may also be examined to see if they reflect changing social conditions. The increased participation of women in the work force and the change in the "traditional" family have led to proposals for earnings sharing among couples and other modifications of the way social security treats women. II–B projections show that the labor force participation rates for women will increase in the future, but remain below those of men.[31]

Proposals to make social security's future treatment of women more fair seem to have two basic perspectives. One would improve the relative position of women who work or are divorced. If costs are not to be raised, payment for increased benefits would come from a reduction in benefits for other workers. Another perspective would be to reduce or eliminate spousal dependent benefits. It has been postulated that in the next century "women without ten years of paid work will be primarily those who have been disabled (for whom there is a social security permanent disability benefit), the very wealthy, and a few women who have relatively large families."[32] Thus, it has sometimes been recommended that the dependent spouse retirement and survivor benefit be gradually reduced or eliminated, on the basis that (1) the fewer number of spouses qualifying for it would not really need it, and (2) it would eliminate the disadvantage two-earner couples usually have compared to single-earner couples, an inequity often mentioned in regard to social security's treatment of women. Increasing work by divorced spouses is also cited, not only as a reason for no longer needing dependent spouses' benefits, but as evidence of the inappropriateness of continuing the concept of the traditional family as the basis for social security benefits.[33]

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[31] 1987 OASDI Trustees' Report, p. 83.

[32] Campbell, Rita Ricardo. Retirement Income. National Journal Issues Book. 1980. p. 69.

Nevertheless, women are still projected to work less, and may continue to earn less, than men. It may be felt that protection for dependent spouses should be left more or less intact. A pertinent distinction in this discussion is that the two perspectives described above tend to go in opposite directions in regard to the system's costs. This distinction is important because of the role that future benefits and taxes play in analyzing intergenerational equity.

Finally, it has been suggested that the shift in the profile of the population may result in future labor shortages, and that this could cause many workers who would otherwise choose to retire to remain in the workforce. If there were more workers for each retiree than is currently projected, it probably would reduce pressure on all sources of retirement income, public and private. The cost of these systems may or may not be lower—depending on whether work tests or actuarial adjustments apply—but more workers would mean greater contributions to these systems. Also, a short supply of labor may drive up its costs, so that increased wages could perhaps offset the rising costs of providing for the retirement of the baby boom. On the other hand, if people delayed retirement, more workers might lead to higher economic output than would otherwise occur, which would enable society to meet better the needs of those who do retire.[34]

The Nation may decide different ways of dividing the roles of social security and private means in providing future retirement income, but it should not be assumed that potentially higher retirement costs can be provided simply by building up the social security trust funds, or by altering the means by which those higher costs are financed. In the final analysis, by whatever means retirement income is provided in the future, the wrench produced on society by the retirement of the baby boom in the next century may be affected only marginally by market conditions then or by changed policies or attitudes about later retirement. It is probable that no matter how much economic wealth can be converted to provide given levels of retirement income, the amount of goods and services that will be available at that time will depend heavily on the part of the population able and willing to produce them.[35] Finally, because of the way social security benefits are determined and financed, economic growth in and of itself will probably not substantially change the effect of the retirement of the baby boom on social security.

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[33] Ibid., p. 70.
[34] Koitz.
[35] Ibid.

Reproduced from U.S. Congress. Senate. Special Committee on Aging. Developments in aging: 1986, volume 1; a report pursuant to S. Res. 353, SEC. 19, Mar. 13, 1986 resolution authorizing a study of the problems of the aged and aging. Washington, G.P.O., 1987. p. 2-16. (Report, Senate, 100th Congress, 1st session, no. 100-9, volume 1)

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. Background

Old age and survivors insurance [OASI] and disability insurance [DI] benefits are the basic benefits provided under title II of the Social Security Act. They are based on a worker's earnings in Social Security covered employment and are designed to replace a portion of the income that individuals and families lose when workers retire, die, or become disabled. At the end of September 1986, 37.5 million beneficiaries under the OASDI Program were receiving $16.2 billion in monthly cash benefits. Retired workers numbered 22.8 million and accounted for 61 percent of all OASDI beneficiaries. Disabled workers numbered 2.7 million and accounted for 7 percent of the total. Average monthly benefit amounts payable in September were $482 both for retired and for disabled workers.

The functions of the Social Security Administration touch the lives of nearly every American. During 1985, about 122 million workers made contributions to the OASDI program. At the end of September 1985, 36.9 million persons were receiving monthly OASDI benefits payments. Administration expenses represented about 1.2 percent of benefit payments in fiscal year 1985. More than 270 million Social Security numbers have been issued and an estimated 235 million persons have sufficient earnings credits to qualify for retirement and survivors protection.

(A) HISTORY AND PURPOSE

Enacted in 1935, the Social Security Program was designed to begin as a modest program with a relatively low tax rate and grow in stages until it reached maturity in the 1980's. As its architects anticipated, Social Security has only recently come of age, with the first generation of lifelong contributors retiring and beginning to draw benefits. While Social Security has expanded and changed substantially over the course of its development, the basic principles which guided the framers of the old-age pension program in 1935 have remained unaltered.

The design of Social Security reflects a compromise among a variety of purposes. This compromise is both a key to the program's broad-based political support and a cause of much of the criticism it receives. For while Social Security provides a mixture of insurance protection, earned pension benefits, and minimally adequate income in old age, it must make separate concessions in the value of each to achieve a combination that works. One current method of criticizing the program has been to evaluate the quality of benefits from only one perspective. For instance, many point to the possibility that rates of return on Social Security taxes paid by the highest wage earners may, in the long run, compare poorly with the rates of return on private investments. While it may be popular when discussing Social Security with a younger worker to focus on only one aspect of the system, this results in a distorted evaluation of the larger purposes of Social Security.

To ensure an accurate picture of the program, there are a number of features that should be factored into any equation which attempts to measure the value of Social Security.

First, Social Security provides younger workers with protection from the unpredictable and random costs of financial support for their own aged parents and relatives. The pay-as-you-go financing for Social Security, seen from this perspective, uses periodic payments by younger workers to insure their own earnings against the cost of parental support. By spreading these costs across the working population, younger workers have a smaller, fairer, and more predictable financial burden, and their parents have a degree of financial independence. This aspect of the program justifies univerals coverage, since exemptions from coverage permit individuals to pass to others the costs of supporting their own parents. It also justifies features which will provide adequate retirement and survivors benefits so that younger workers will be fully protected from having to supplement the incomes of their relatives.

Second, Social Security provides workers and their families with a "floor of protection" against suddent loss of their earning due to their own death, disability, or retirement. This insurance is intended to protect only a portion of the income needed to preserve the previous living standard of the worker and his family, and is to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker. Receipt of benefits is based on the occurrence of an insured-against event, such as retirement, which is determined by comparing the individual to some "test" or standard, such as the retirement or earnings test. Should the individual meet the test, benefits are then provided regardless of any income from other sources.

Third, Social Security provides the individual wage earner with a basic pension benefit upon retirement. Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating service credits. This mixture of features in Social Security has been the source of public confusion about the program over the years. The similarities between Social Security and a pension, for example, have led many people to believe that the system is funded, as a private pension might be, through workers' contributions invested in a trust fund account and used to pay benefits in the future. Others focus on the rate of return on contributions—as if Social Security were a form of individual investment.

A program with the essential social functions and multiple purposes of Social Security defies comparison with other financial or insurance vehicles. While a particular vehicle, such as an individual retirement account [IRA], may perform one function more successfully for some than does Social Security, no single vehicle could perform the unique combination of functions without approximating Social Security in its features. Most criticisms of Social Security, therefore, readily translate into criticisms of its mix of functions. For example, some critics believe Social Security ought to be only a pension plan, leaving the insurance and intergenerational support functions to specially tailored alternative programs. Others argue that Social Security should be a welfare program, providing basic benefits to the poor, and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRA's. Though the use of separate programs would eliminate the compromises entailed in Social Security, it could also raise tremendously the total cost of performing all of Social Security's functions, and most likely jeopardize the widespread political support that has developed for the program.

The Social Security Program, which was created during the Great Depression, is only now becoming a mature social insurance program. The decade of the 1980's marks the first generation of lifelong contributors retiring and beginning to draw benefits. Also during this decade, it is expected that payroll tax rates, eligibility requirements, and the relative value of monthly benefits will finally stabilize at the levels planned for the system.

(B) FINANCING

(1) Financing in the 1970's

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to meet any disruptions in expenditures or income due to unforeseen economic fluctuations. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: Relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecasted. High levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 had not only increased benefits by 20 percent across the board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974–75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "overindexing" benefits for certain new retirees, and thereby created an additional drain on trust fund reserves.

Recognizing that the financial status of the Social Security trust funds was rapidly deteriorating, Congress responded by enacting the Social Security Amendments of 1977. The 1977 legislation increased payroll taxes beginning in 1979, reallocated a portion of the Medicare [HI] payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount. These changes were predicted to produce surpluses in the OASDI Program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as forecasts had predicted. The long-term deficit, which had not been fully reduced, remained. After 1979, annual increases in the CPI exceeded 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI Program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

The 96th Congress responded to this crisis by temporarily reallocating a portion of the DI tax rate to OASDI for 1980 and 1981. This measure was intended to postpone an immediate financing crisis in order to allow time for the 97th Congress to comprehensively address the impending insolvency of the OASDI trust funds. In 1981, a number of proposals were introduced to restore short- and long-term solvency to Social Security. However, the debate over the future of Social Security proved to be very heated and controversial, and enormous disagreements on policy precluded quick passage of comprehensive legislation. At the end of 1981, in an effort to break the impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Commission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay imposed by the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. But the Commission did provide clear guidance to the new Congress on the exact dimensions of the various financing problems in Social Security, and on a viable package of solutions.

(2) The Social Security Amendments of 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, Congress moved quickly to enact legislation to restore financial solvency to the OASDI trust funds. This comprehensive package improved financing by $166 billion between 1983 and 1989, and eliminated a deficit which had been expected to average 2.1 percent of payroll over 75 years.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions for new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI Program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions included:

Coverage.—All Federal employees hired after January 1, 1984, were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.

Benefits.—COLA increases were shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A COLA fail-safe was set up so that whenever trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20 percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.

Taxation.—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—were made subject to income taxation, with the additional tax revenue to be funneled back into the retirement trust fund.

Payroll taxes.—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement age increase.—An increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between the year 2000 to 2022.

The 1983 amendments have caused a major improvement in the condition of the OASDI trust funds. Based on intermediate assumptions, it is expected that reserve ratios will increase from a low of 11 percent of annual outgo at the beginning of 1983 to 47 percent of outgo by the beginning of 1989. These reserves should be sufficient to continue uninterrupted benefit payments throughout the decade, and repay the HI trust fund for previous loans.

(3) OASDI Near-Term Financing

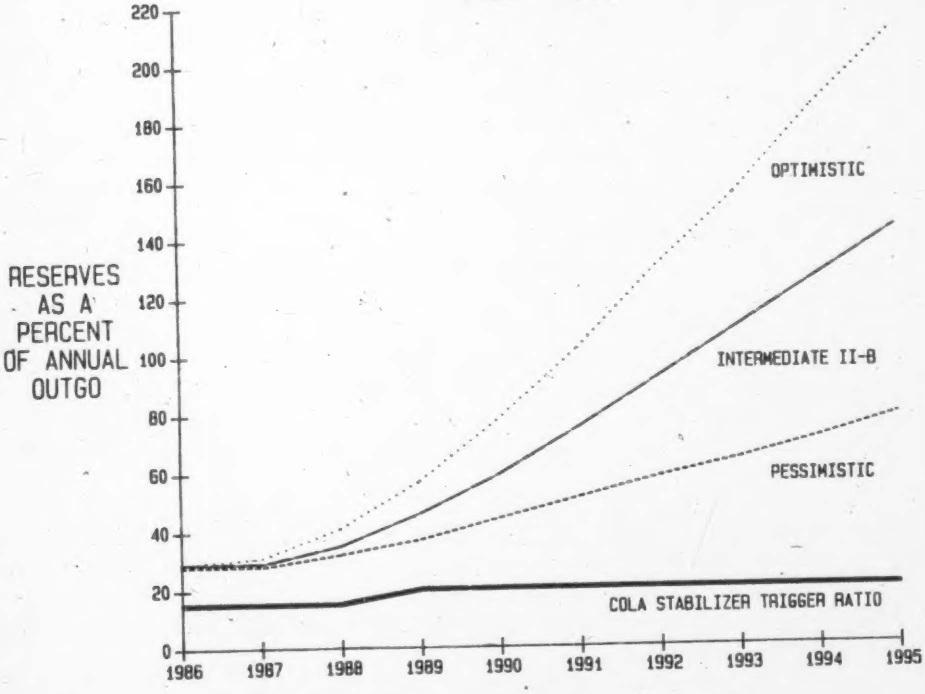
In the short term, OASDI funds are anticipated to increase steadily each year under all but the most pessimistic assumptions employed by Social Security actuaries. Under pessimistic assumptions, reserve ratios are expected to decline slightly, and then increase again in 1988. The short-range estimates reported in the 1986

Social Security trustees report are more favorable than those that informed the 1983 legislative efforts, due to the strength of the economic recovery. It is likely that in the aggregate, the OASDI trust funds will continue to grow faster than anticipated in the 1983 legislation, even though the costs of the DI program can be expected to increase as a result of the 1984 DI reform legislation.

Overall, the OASDI reserves are expected to expand considerably in the near future. Only in the next 2 years, until the scheduled 1988 payroll tax increase goes into effect, are the reserves at all slim. Under all sets of assumptions in the 1986 Social Security trustees report, the OASDI contingency funds are expected to remain between 28 and 31 percent of projected outgo until 1988. Beginning in 1988, the OASDI reserves are expected to begin a steady buildup as a result of the scheduled 1988 and 1990 tax increases and an anticipated leveling off in the growth rate of new retirees. Under intermediate assumptions, the OASDI contingency funds are expected to grow from 35 percent of outgo in 1988 to 143 percent by 1995.

CHART 1-1

OASDI RESERVE RATIOS UNDER ALTERNATIVE ASSUMPTIONS
1986 - 1995



SOURCE: 1986 Report of the Trustees of the OASDI Trust Funds

TABLE 1-1.—COMBINED OASDI RESERVE RATIOS AS A PERCENTAGE OF ANNUAL OUTGO UNDER ALTERNATIVE ASSUMPTIONS: 1986–1995

Calendar year	Optimistic	Intermediate II–B	Pessimistic
1986	29	29	28
1987	31	29	28
1988	41	35	32
1989	57	46	37
1990	78	59	44
1991	102	75	51
1992	130	92	58
1993	155	109	64
1994	185	126	71
1995	211	143	79

Source: 1986 Trustees report, table 31, p. 75.

(4) OASDI Long-Term Financing

In the long run, the Social Security trust funds appear to be in close actuarial balance, meaning that over the next 75 years, it is projected that the taxes collected for Social Security will fall within plus or minus 5 percent of the amount needed to pay benefits. Under current projections based on intermediate assumptions, the trustees predict that the trust funds will remain solvent throughout the next 75 years.

Although the OASDI trust funds remain healthy, under forecasts for the long term it should be emphasized that trust fund experience in each of the three 25-year periods between 1986 and 2060 varies considerably. In the first 25-year period—1986 to 2010—the trust funds are expected to accumulate rapidly, and maintain an annual surplus of revenues equal to 2.12 percent of taxable payroll. As a result of these surpluses, OASDI reserves are expected to build to over 200 percent of annual outgo by the year 2000.

In the second 25-year period—2011 to 2035—the financial condition of OASDI is expected to continue improving in the early years, but begin deteriorating toward the end of the period. Trust fund reserves are expected to grow to over 500 percent of annual expenditures by 2015, and then decline, reaching 258 percent of outgo by 2035. The combination of surpluses and deficits will result in an average deficit of 0.89 percent of taxable payroll over this 25-year period.

The third 25-year period—2036 to 2060—is expected to be one of continuous deficits. Program costs will grow until 2035 and level off, remaining above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Annual deficits over the 25-year period are expected to average 2.56 percent of taxable payroll.

TABLE 1-2.—COMPARISON OF ESTIMATES COSTS RATES AND INCOME RATES OF THE OASDI PROGRAM, ON THE BASIS OF ALTERNATIVE II-B, CALENDAR YEARS 1986–2060

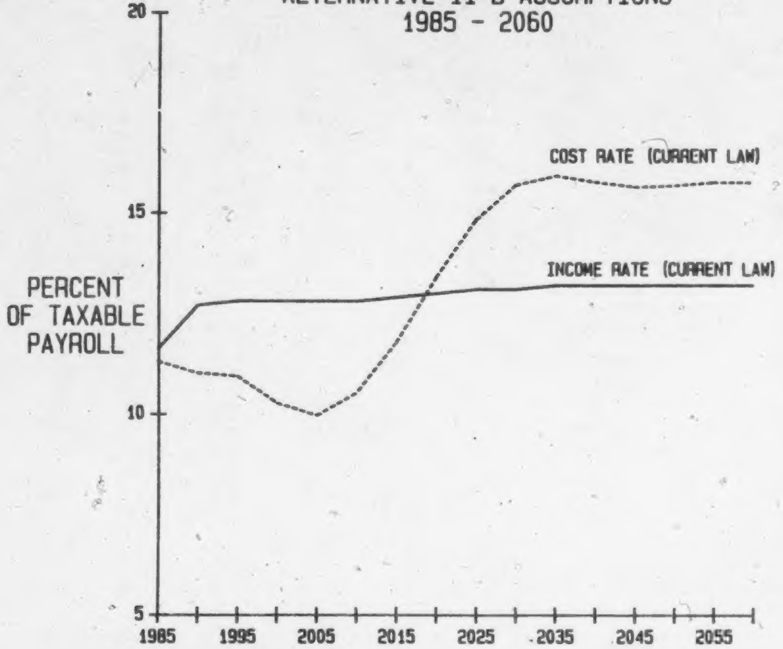
[As a percentage of taxable payroll]

Calendar year	Cost rate			Income rate			Balance
	OASI	DI	Total	Payroll tax	Taxation of benefits	Total	
Alternative II-B:							
1986	9.98	1.13	11.11	11.40	0.21	11.61	0.50
1987	9.93	1.09	11.02	11.40	.22	11.62	.60
1988	9.99	1.07	11.07	12.12	.24	12.36	1.30
1989	9.89	1.05	10.94	12.12	.26	12.38	1.45
1990	9.96	1.04	11.00	12.40	.34	12.74	1.74
1991	9.94	1.03	10.96	12.40	.31	12.71	1.75
1992	9.90	1.02	10.92	12.40	.33	12.73	1.82
1993	9.88	1.01	10.89	12.40	.36	12.76	1.87
1994	9.88	1.02	10.90	12.40	.39	12.79	1.89
1995	9.90	1.03	10.92	12.40	.43	12.83	1.91
2000	9.13	1.12	10.25	12.40	.41	12.81	2.55
2005	8.64	1.31	9.95	12.40	.39	12.79	2.84
2010	8.96	1.55	10.51	12.40	.43	12.83	2.32
2015	10.08	1.69	11.77	12.40	.50	12.90	1.13
2020	11.62	1.77	13.40	12.40	.58	12.98	−.41
2025	12.96	1.88	14.84	12.40	.67	13.07	−1.77
2030	13.85	1.84	15.70	12.40	.73	13.13	−2.57
2035	14.15	1.78	15.93	12.40	.76	13.16	−2.78
2040	14.00	1.77	15.77	12.40	.77	13.17	−2.60
2045	13.82	1.83	15.65	12.40	.79	13.19	−2.46
2050	13.83	1.86	15.69	12.40	.79	13.19	−2.50
2055	13.92	1.85	15.77	12.40	.79	13.19	−2.57
2060	13.95	1.82	15.77	12.40	.79	13.19	−2.58
25-year averages:							
1986–2010	9.37	1.17	10.54	12.30	.37	12.67	2.12
2011–2035	12.13	1.78	13.91	12.40	.62	13.02	−.89
2036–2060	13.92	1.82	15.74	12.40	.78	13.18	−2.56
75-year average:							
1986–2060	11.81	1.59	13.40	12.37	.59	12.96	−.44

Source: 1986 Trustees report, tables 28 and 29.

CHART 1-2

ESTIMATED OASDI COST AND TAX RATES
ALTERNATIVE II-B ASSUMPTIONS
1985 - 2060



SOURCE: 1986 Report of the Trustees of the OASDI Trust Funds

(a) Midterm surpluses

In the years between 1990 and 2025, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these surpluses will be invested in interest-bearing Federal securities, and will be redeemable to Social Security in the years in which benefit expenditures exceed payroll tax revenues—2025 through 2060. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these surplus funds, and the political and economic implications they entail.

During the period in which Social Security trust fund surpluses are accumulating, the surplus funds can be used, indirectly, to finance other Government expenditures or reduce the public debt. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

Though net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two methods have vastly different distributional consequences.

Social Security is fiananced by a regressive payroll tax, whose regressivity is justified on the basis that the benefit structure is progressive. The key policy issue is the significance of either scenario in the larger picture of the total Federal budget. In both instances, there is an incentive to spend surplus revenues in the 1990's and cut back on underfunded benefits after 2020.

What will happen to the surpluses Social Security lends to the general fund? These funds will enable Congress to spend money elsewhere without raising taxes or borrowing. This money could be used to fund new Federal programs, to reduce and possibly eliminate the budget deficit, or, with sufficient surpluses, to pay off the national debt. What will happen when this debt has to be repaid to Social Security? Either general revenues will have to be increased, or spending will have to be cut.

There are a number of alternative policy options for addressing the surplus/shortage problem. One choice would be simply to cut OASDI taxes in the coming decades, and encourage workers to save privately for their retirement—through tax favored IRA's for example—and reduce future Social Security benefits for those who do so. Alternatively, Congress could choose to create a floating tax rate, which would increase or decrease in direct relation to expenditures. This method would conform to the pay-as-you-go model of financing. Another option would be to direct a portion of the surplus OASDI revenues to the Medicare [HI] trust fund, which is expected to face severe financing problems in the coming years.

(b) Long-term deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The first part of this problem is that there are expected to be proportionately more older people, living longer, and continuing to retire early. Second, unusually high birth rates after World War II have already created a bulge in the population—the baby-boom generation—which is expected to reach retirement age beginning in 30 years. If life expectancy continues to rise and fertility rates stay low, as currently expected, the magnitude of this problem will be very great.

The relative increase in the number of beneficiaries per worker will not necessarily threaten the solvency of Social Security if productivity gains in the future compare to the experience of the past 30 years. Even though the ratio of workers to beneficiaries may decline, this can be offset by economic growth and increased real wages.

Another way of describing this is to point out that while the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not necessarily increase greatly over levels experienced in the 1970's. Currently, Social Security benefits cost 4.9 percent of the GNP. Under intermediate assumptions—

with 1.5 percent real wage growth—Social Security is expected to rise to 6.3 percent of the GNP by 2030, declining to 5.8 percent by 2060.

However, this relative increase in the number of beneficiaries will be a problem, despite productivitiy increases, if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-third of payroll from Social Security taxes. This would be a substantial erosion of the Social Security tax base, and might undermine the long-term solvency of the system.

At this time, there are neither short-term nor long-term deficits projected in the OASDI trust funds, and though there are a wide variety of issues that must be considered in the future, there is no compelling need for Congress to make major changes in Social Security in the near-term. However, it should be emphasized that Social Security is vulnerable to general economic conditions, and should they deteriorate, Congress may need revisit the financing of the system. Furthermore, Social Security may be subject to external political pressures to change its structure, notwithstanding its financial condition. Congress may well ignore the internal solvency of Social Security in the coming years and cut benefits in order to lower Federal deficits.

2. Issues

(A) SOCIAL SECURITY'S RELATION TO THE BUDGET

Since 1981, the Congress has worked continuously through the annual process of deciding on a Federal budget to limit Government spending and reduce growing Federal deficits. In response, many advocates have proposed separating decisions about the operations of the Social Security Program from the Federal budget process. As a major part of total Federal income and outlays, Social Security has stood out as a prime target for budget cutting proposals. Social Security cuts were made as part of the 1981 budget reconciliation bill and subsequently proposals have been advanced to defer or freeze the annual cost-of-living adjustments [COLA's].

At the heart of this debate lie fundamental differences of perspective regarding the relation of Social Security to other Government programs. Advocates of removal from the budget process cite several reasons in support of their position: (1) Social Security has long-range goals—it aims to provide retirement income and disability insurance that all Americans can rely on for the future—that are incompatible with the short-term revenue and spending concerns of the yearly budget cycle; (2) Social Security is funded by a separate payroll tax that is deducted from the Social Security trust funds, so the effects of a shortage of revenue or an excess of spending in other areas of the budget should not be allowed to spill over into the Social Security program; (3) inclusion of Social Security in the budget allowed the politics involved in the budget debate to complicate and confuse policy questions regarding the future of Social Security; and (4) confidence in the system suffers by the impression that retirement plans must be constantly adjusted in response to the changing political climate.

Those who support inclusion of Social Security in the budget process make several points: First, that the Federal budget contains many programs that fulfill long-range goals, and that Social Security should not be excepted; second, that it is impossible to comprehensively confront the Government's taxing and spending problems without including Social Security, which will account for roughly 20 percent of Government outlays in fiscal 1987; third, that despite its long-range goals, Social Security should remain responsive to political processes, which rightly control all of government in a democracy.

Another aspect of the debate centers on the effect on the budget process of the expected surpluses in the Social Security trust funds. In 1987 the system is expected to take in approximately $15 billion more in taxes than it pays in benefits. By 1990, after two scheduled payroll tax increases, the yearly surplus will amount to an expected $55 billion. Many feel that the inclusion of this large surplus in the budget disguises the magnitude of the deficits created by the balance of the Government's taxing and spending policies, and might reduce the pressure on Congress to reduce those deficits.

The off-budget issue has been partially resolved by the 1983 Social Security Amendments and by the Gramm-Rudman-Hollings Act in 1985. The 1983 amendments required Social Security to be removed from the budget process by fiscal year 1993. Gramm-Rudman-Hollings accelerated the removal to fiscal year 1987, but that removal turned out to be less than total. Under the Gramm-Rudman-Hollings Act it is more difficult, but not impossible to consider transfers in Social Security benefits as part of a budget resolution or reconciliation bill. Social Security income and outlays are to be excluded from budget documents, budget resolutions, and reconciliation legislation.

However, under Gramm-Rudman-Hollings, Social Security's annual surpluses or deficits are taken into account in the calculation of the deficit targets. Were it not for the inclusion of the large Social Security surpluses, the budget deficit would have to be cut by an additional $50 to $60 billion in order to meet the targets set for the final years of Gramm-Rudman-Hollings.

(B) DISINVESTMENT OF THE TRUST FUNDS

Confidence in the Social Security system suffered a blow, and substantial confusion was generated as a result of actions taken by the Treasury Department during the debt ceiling crisis of late 1985. In September, Treasury began to run out of cash as it approached the debt ceiling, thus losing its ability to borrow from the general public to fund the Government's operating deficit. In order to generate cash for the purpose of making benefit payments, Treasury "disinvested" or cashed in long-term securities held by the old age and survivors insurance [OASI] and disability insurance [DI] trust funds. The public generally perceived that Treasury had used trust fund assets to operate other Government programs. Many also protested the loss of interest that the funds would have suffered when the disinvested amounts were reinvested in long-term securities in June of 1986. Interest loss would have resulted due to the lower interest in 1986. The impact of the problem was compounded by the revelation, in hearings before the Senate Finance Committee, that Treasury had previously disinvested Social Security funds in August of 1984, with a loss of interest and without notifying Congress of its actions.

The problem surfaced again in 1986, when Treasury reached the debt ceiling on September 30 and was unable to credit the trust funds with an advance payment of payroll tax revenues. The trust funds did not lose interest however, because, despite its lack of borrowing authority, Treasury had sufficient cash to pay benefits in early October without disinvesting. However, it was apparent that a serious loss of confidence could result if Congress did not take some action to prevent or at least regulate Treasury's disinvestment practices.

Disinvestment of the trust funds was made possible by virtue of the relationship between assets of the trust funds and the calculation of the debt ceiling. The debt ceiling as presently calculated includes not only debt issued by the Treasury to the private sector, which totalled $1,703 billion at the close of July 1986, but also Treasury debt issued to various Federal trust funds, which totalled $346 billion. The principal trust funds holding Treasury debt are the Social Security OASI, DI, and Hospital Insurance [HI] and the Black Lung, Highway, Airport, Military Retirement, Railroad Retirement, Civil Service Retirement, Revenue Sharing, Foreign Military Sales, and Toxic Waste Superfund trust funds.

Debt issued to trust funds is fundamentally different from debt issued to the private sector. Trust fund debt generally arises as a result of the method which Treasury uses to account for the receipt of tax revenues which are dedicated to a specific purpose. In the case of the Social Security Old Age and Survivors Insurance Trust Fund for instance, Treasury credits the fund at the beginning of each month with the estimated amount of payroll retirement taxes that it expects to receive during the course of the month. The credit to the fund takes the form of short-term special debt issues—a type of security which is in effect an internal Government I.O.U. from Treasury's operating cash account to the retirement fund. Although these securities do not represent debt issued to the general public, they are included in the calculation of total Government debt for purposes of the "debt ceiling"—the statutory limit on total Government borrowing. These securities are cashed in over the course of the month as the general revenue account pays out benefits. When payroll taxes exceed benefits, as they currently do, securities accumulate in the trust fund accounts. On June 30 of each year, the accumulated securities are converted to long-term special debt issues, which also count against the debt ceiling. The balance in the trust fund thus represents the total amount by which payroll retirement taxes have exceeded benefits paid.

The disinvestment of the Social Security trust funds in response to the debt ceiling crisis resulted from the fact that the securities held by the trust funds are part of the total Government debt for purposes of calculating the debt ceiling. When total debt began to approach the debt ceiling, Treasury found itself short of cash and was unable to issue new debt to the public to raise cash. Because Social Security benefit payments must be made each month before the month's payroll taxes are received, the Treasury must use its cash reserves to pay benefits during the first week of the month. The Secretary of the Treasury, who is also managing trustee of the Social Security trust funds, chose to convert long-term securities held by the trust funds into bonds which could be sold to the general public, thus generating cash which was used to pay benefits. In effect, Treasury was able to exchange one form of debt for another without going past the ceiling.

If the special debt issues held by the funds did not count in the calculation of the debt ceiling, Treasury would not have been able to convert the trust fund's holdings into cash. However it would have also prevented the Treasury from making benefit payments as it ran out of cash. This does not necessarily mean that a benefit payment would have been missed, because, when confronted with debt crises in the past, Congress has always provided temporary debt ceiling extensions that allowed payment of benefits. The inclusion of trust fund debt in the debt ceiling merely provided Treasury with a means of delaying the inevitable debt crisis.

However, while Treasury was able to make benefit payments on time in the face of debt crises, its disinvestment of the funds drew criticism for several reasons. First, disinvestment allowed the Treasury to temporarily avoid the effect of the statutory debt ceiling. Second, disinvestment created the impression that Congress was not vigilant in supervising Treasury's management of the trust funds. Third, disinvestment raised fears that the trust funds and payroll taxes were being used to fund non-Social Security programs—an ominous precedent in view of the expected rapid growth in trust fund reserves. Fourth, disinvestment created a general feeling of confusion, with a corresponding loss of confidence in the future of the trust funds. These criticisms have given rise to several proposals to prevent or regulate disinvestment, none of which satisfies all critics.

One suggested solution is to remove trust fund debt from the calculation of the debt ceiling. The attractiveness of this solution is that it provides a simple means of preventing future manipulation of the trust funds without impeding Treasury's ability to conduct routine transactions and investments. It would also further the policy goal of distinguishing the Social Security taxation and benefit process from the balance of the Government's taxing and spending programs.

Furthermore, critics maintain that inclusion of trust fund balances in the debt ceiling does not serve the ostensible purposes of a limit on borrowing by the Treasury. To the extent that the debt ceiling is intended to represent the degree to which Government has financed its programs by borrowing from the private sector, the trust fund balances distort the picture—trust funds merely represent one Treasury account borrowing from another. This distortion will increase in the future because of the expected growth of the surplus in the Social Security retirement fund from the current $33.9 billion to $584 billion in 1995 and over $2 trillion in 2005. The chief argument against removing trust fund debt from the debt ceiling calculation is that it will create the impression that the Government's debt to Social Security is not as important as debt to private bond holders.

Another proposed solution is to continue to include trust fund balances in the calculation of the debt subject to the debt ceiling, but to prohibit any disinvestment that is done to avoid the ceiling. The primary criticism of this approach is that it would prevent the payment of Social Security benefits during a debt ceiling crisis. Proponents of this approach argue that Congress has always raised the debt ceiling in time to forestall cessation of Government activities. Critics nonetheless believe that the payment of benefits should be insulated from the annual debt ceiling crisis in order to prevent needless fear on the part of recipients that their benefits would be suspended.

A third proposed solution would continue to include the trust funds in the calculation of the debt ceiling and would specifically allow disinvestment for the purpose of paying benefits, providing the Treasury notified Congress beforehand. In essence, this would "legitimize" the disinvestment. Proponents believe that this approach would remove fears that the trust funds were subject to unsupervised manipulation by the Treasury, while at the same time, it would use the trust fund reserves to guarantee the payment of benefits in a debt ceiling crisis. Critics believe that this approach still allows the Treasury to evade the debt ceiling, and sets a bad precedent for use of the trust fund reserves.

(C) ADMINISTRATIVE ISSUES IN SOCIAL SECURITY

Over time, Congress has monitored the performance of the SSA in carrying out its most basic mission—dignified, high quality service to the public. In the 1950's and 1960's SSA was viewed as an elite agency, marked by high employee morale and excellent management. In the past 15 years, however, many have commented that the agency has lost its esprit de corps, and the quality of public service has declined. Factors cited as causing this decline include new agency responsibilities (for example, the creation of SSI in 1972), multiple administrative reorganization efforts, and the fact that SSA has had 10 different Commissioners in the last 14 years. Many claims that public confidence in the agency has declined in recent years and that the agency has sacrificed the quality of service to the public in an effort to improve efficiency and cut costs.

Reproduced from Social Security in review, Social security bulletin, v. 51, Jan. 1988. p. 2-3.

Social Security in Review

Increases in Social Security Program Amounts for 1988

A number of increases in the Old-Age, Survivors, Disability, and Health Insurance (OASDHI) program went into effect on January 1, 1988. The changes are required under the Social Security Act and represent adjustments based on increases in national average wage levels.

The maximum earnings base for Social Security and Medicare taxes rises from $43,800 to $45,000. The contribution rate for employers and employees will be 7.51 percent and the rate for the self-employed will be 15.02 percent. For taxable year 1988, a tax credit of 2.0 percent will apply to the self-employed, reducing their effective contribution rate to 13.02 percent. Under the new provisions, employees and employers will make maximum annual contributions of $3,379.50 and the self-employed will pay as much as $5,859.00.

The annual exempt amount under the earnings test rises from $8,160 to $8,400 for beneficiaries aged 65-69 and from $6,000 to $6,120 for those under age 65. A person may earn any amount without incurring a loss of benefits if he or she is aged 70 or older.

The amount of covered earnings a worker needs to earn a quarter of coverage rises from $460 to $470.

The "bend points" used in calculating the primary insurance amount (PIA) and maximum family benefits will rise for those who become newly eligible for benefits in 1988. The new PIA formula is 90 percent of the first $319 (up from $310) of average indexed monthly earnings (AIME), plus 32 percent of AIME in excess of $319 but not in excess of $1,922 (up from $1,866), plus 15 percent of AIME in excess of $1,922. The maximum family benefit formula is 150 percent of the first $407 (up from $396) of the PIA, plus 272 percent of the PIA in excess of $407 but not in excess of $588 (up from $571), plus 134 percent of the PIA in excess of $588 but not in excess of $767 (up from $745), plus 175 percent of the PIA in excess of $767.

Increases in average wage levels and rises in Social Security program amounts for the period 1976-88 are shown in the table below.

Program Operations

OASDI Benefits

At the end of October 1987, the Old-Age, Survivors, and Disability Insurance (OASDI) program was paying $16.9 billion in monthly cash benefits to 38,161,830 beneficiaries. Retired workers numbered 23,399,758

Average wages and Social Security program amounts for calendar years 1976-88

Calendar year	Average wage	Wage base	Earnings test exempt amount		Maximum OASDHI tax paid by workers		Amount of earnings required for quarter of coverage
			Under age 65	Aged 65-69[1]	Wages	Self-employed	
1976	$9,226.48	$15,300	$2,760	$2,760	$895.05	$1,208.70	$50
1977	9,779.44	16,500	3,000	3,000	965.25	1,303.50	50
1978	10,556.03	17,700	3,240	4,000	1,070.85	1,433.70	250
1979	11,479.46	22,900	3,480	4,500	1,403.77	1,854.90	260
1980	12,513.46	25,900	3,720	5,000	1,587.67	2,097.90	290
1981	13,773.10	29,700	4,080	5,500	1,975.05	2,762.10	310
1982	14,531.34	32,400	4,440	6,000	2,170.80	3,029.40	340
1983	15,239.24	35,700	4,920	6,600	2,391.90	3,337.95	370
1984	16,135.07	37,800	5,160	6,960	[2]2,532.60	[3]4,271.40	390
1985	16,822.51	39,600	5,400	7,320	2,791.80	[4]4,672.80	410
1986	17,321.82	42,000	5,760	7,800	3,003.00	[5]5,166.00	440
1987	...	43,800	6,000	8,160	3,131.70	[5]5,387.40	460
1988	...	45,000	6,120	8,400	3,379.50	[5]5,859.00	470

[1] Aged 65-71 before 1983.

[2] Reflects a tax credit of 0.3 percent of covered wages against 1984 employee Social Security taxes. The maximum tax paid by employers on a worker's earnings was $2,646.00 in 1984.

[3] Reflects a tax credit of 2.7 percent of self-employment income against 1984 self-employment Social Security taxes.

[4] Reflects a tax credit of 2.3 percent of self-employment income against 1985 self-employment Social Security taxes.

[5] Reflects a tax credit of 2.0 percent of self-employment income against 1986, 1987, and 1988 self-employment Social Security taxes.

and accounted for 61 percent of all OASDI beneficiaries. Disabled workers numbered 2,776,138 and accounted for 7 percent of the total. Average monthly benefit amounts payable in October 1987 to retired and disabled workers were $491.75 and $487.52, respectively.

During June 1987, 305,016 monthly cash benefits were awarded. Forty-three percent of all awards were made to retired workers and 12 percent were made to disabled workers. Eighty-eight percent of all awards and 85 percent of awards to retired workers were immediately payable. The average monthly benefit amounts for these immediately payable awards were $437.30 for retired workers and $493.97 for disabled workers.

SSI Payments

Federally administered payments. In October 1987, 4,354,200 persons received federally administered Supplemental Security Income (SSI) payments, up 3,100 from the September figure. The number of disabled recipients increased by 3,600 to 2,816,300. The number of aged recipients decreased by 300 to 1,454,800 and the number of blind recipients declined by 200 to 83,100.

OASDI	October 1987	September 1987	October 1986
Monthly beneficiaries, total (in thousands)	38,162	38,093	37,607
Aged 65 or older, total	27,693	27,634	27,150
Retired workers	20,844	20,794	20,387
Survivors and dependents	6,829	6,819	6,737
Special age-72 beneficiaries	20	20	26
Under age 65, total	10,469	10,459	10,457
Retired workers	2,555	2,561	2,516
Disabled workers	2,776	2,770	2,717
Survivors and dependents	5,138	5,128	5,224
Total monthly benefits (in millions)[1]	$16,873	$16,832	$16,265
Average benefit in current-payment status:			
Retired workers	$491.75	$491.53	$481.89
Disabled workers	487.52	487.49	481.80
Aged widows and widowers	445.75	445.25	435.07
Children of deceased workers	338.02	337.81	332.29
Average benefits awarded:[2]			
Retired workers	$461.49	$460.14	$447.99
Disabled workers	492.46	490.00	476.73
Aged widows and widowers	452.60	450.57	436.86
Children of deceased workers	331.51	328.17	323.48

[1] In current-payment status; excludes lump-sum and retroactive payments and adjustments.

[2] Based on benefits awarded during the month, not benefits immediately payable in that month.

Federally administered payments in October totaled $1,082.3 million, up $5.4 million from the previous month. Federal SSI payments rose by $4.9 million to $861.8 million, and federally administered State supplementation increased by $520,000 to $220.5 million.

The average federally administered payment in October was $248.57. The averages were $180.16 for the aged, $295.05 for the blind, and $282.53 for the disabled.

State-administered supplementary payments. In July 1987, 268,400 persons were receiving State-administered supplements—an increase of about 150 from the previous month. During this 1-month period, expenditures increased to $28.9 million. Of the 25 States reporting, 6 had increases in both caseload and expenditures, 6 had decreases in both, 4 had either an increase or decrease in one or the other, and 9 reported no change.

SSI	October 1987	September 1987	October 1986
Recipients of federally administered payments, total (in thousands)	4,354	4,351	4,230
Aged	1,455	1,455	1,473
Blind	83	83	83
Disabled	2,816	2,813	2,674
Federally administered payments, total (in millions)	$1,082	$1,077	$1,015
	July 1987	June 1987	July 1986
Recipients of State-administered payments, total (in thousands)	268	268	279
Aged	112	112	126
Blind	3	3	3
Disabled	143	143	140
State-administered payments, total (in millions)	$29	$29	$28

Reproduced from U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment. The forgotten safety net: the supplemental security income (SSI) program. Hearing, 100th Congress, 1st session. Sept. 10, 1987. Washington, G.P.O., 1988. p. 88-92.

APPENDIX 2

STAFF BRIEFING PAPER FOR

"THE FORGOTTEN SAFETY NET: THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM"

A HEARING BEFORE THE SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT

SELECT COMMITTEE ON AGING

SEPTEMBER 10, 1987

(This document has been printed for informational purposes only.
It does not represent either findings or recommendations adopted by the Subcommittee.)

THE FORGOTTEN SAFETY NET: THE SUPPLEMENTAL SECURITY INCOME PROGRAM

BRIEFING PAPER

The purpose of this hearing is to review the progress that the SSI program has made in achieving its objective of assuring a minimum income to the aged, blind, and disabled. The hearing will identify problems within the SSI program and examine the need for program improvements to alleviate poverty among the elderly and disabled.

History of SSI

The Social Security Act of 1935 provided, among other things, grants to the states for assistance to the needy aged, the blind, and dependent children.

By 1940 Old Age Assistance (OAA) provided economic support to the needy elderly. However, the programs were highly decentralized, with more than one thousand (1,000) different State, county and local welfare plans. There were different eligibility criteria, intrusive eligibility investigations to determine individual need, and wide variations in benefit levels.

SSI

The SSI program was established in 1974 to provide a nationally uniform guaranteed minimum income for the aged, blind, and disabled. The program has national uniform standards to determine program eligibility. The minimum cash grant is wholly federally financed by general revenues and administered by a federal agency, the Social Security Administration (SSA).

The intent of the program was to supplement the income of poor persons whose work experience and/or circumstances did not qualify them for coverage under Social Security, or whose benefits under Social Security were inadequate for subsistence.

The original legislation set the Federal SSI benefit standard below poverty thresholds. In 1974, the year of implementation, benefit amounts were 85% of poverty for aged couples, and 71% for aged individuals. Today benefits are 76% of the poverty level for individuals and 90% for couples.

Not only were Federal SSI benefits set lower than poverty thresholds, but they were also lower than prevailing OAA levels in 25 states. Prior to implementation, Congress mandated that all states with pre-SSI benefits above the federal minimum supplement the federal payment so that those higher benefits would continue. Voluntary state supplementation to the Federal SSI benefit standard was designed to permit states to meet needs, arising from higher living costs in certain geographic areas or in certain living arrangements, as they perceive them. Currently SSA administers over half of the state supplementation.

BASIC ELIGIBILTY

The program covers persons age 65 and over, blind, and disabled people of any age, whose income and resources are below specific levels and who meet other requirements.

Individuals and couples applying for or receiving SSI benefits are determined to be eligible if their countable income does not exceed certain income benefit standards.

The following definitions are used:

Aged: Persons 65 years and older

Blind: Persons with 20/200 vision or less, with the use of corrective lenses ,in the person's better eye, or those with tunnel vision of 20 degrees or less.

Disabled: Persons unable to engage in substantial gainful activity, due to a medically determined physical and/or mental impairment, expected to result in death, or that has lasted or can be expected to last for at least 12 months.

Federal Benefit Standard

The amount of the monthly Federal SSI payment is determined by the recipient's countable income, living arrangement, and marital status. The Federal SSI benefit standard is the floor of income assured by the program for people with no countable income.

In 1987 the Federal SSI benefit standard for an individual, living in his own household, with no countable income, is $340 a month, and a couple, living in their own home is entitled to $510.

Actual benefit payments are computed by subtracting the individual's/couple's countable income from the benefit standard.

The Federal SSI benefit standard is indexed annually to the CPI by the same percentage as Social Security benefits.

Most states supplement the regular Federal SSI benefit. The result is a combined regular Federal SSI/State Supplementation benefit standard against which accountable income is compared in determining eligibility and benefit amount.

Income (Earned and Unearned)

Income is defined as the earnings, Social Security checks, annuities, and other checks and cash one receives. Income can also mean any items one receives instead of cash, such as food or shelter.

Income disregard — Some income is not counted in determining eligibility. Currently, $20 of monthly income from any source, usually Social Security for the aged, is disregarded. In addition, the first $65 a month one earns, plus one-half of the remaining earnings, are not counted in determining eligibility. The value of in-kind assistance provided by federally assisted or state or local government programs; for example, nutrition services, food stamps, housing or social services, are also disregarded.

Assets (Resources)

SSI eligibility is restricted to qualified persons who have countable assets of less than a specific amount. In 1987 the asset limit is $1,800 for an individual and $2,700 for a married couple.

Assets are defined as things one owns such as real estate, personal belongings, a car, savings and checking accounts, cash, stocks and bonds.

Some assets are not counted: the home one lives in, household goods and personal effects with a limit of $2,000 in equity value, $4500 of the current market value of a car (and if one uses it for medical treatment or employment it is totally excluded); burial plots for individual and immediate family members; a maximum of $1500 in burial funds for an individual, and a like amount for one's spouse.

The income of an ineligible spouse who lives with the SSI recipient or applicant is considered in determining the eligibility and amount of benefits paid to the individual.

Dependent Living Arrangements

If an applicant or recipient is living in another person's household and receiving support and in-kind maintenance from a person, such as groceries, the value of the assistance is presumed to equal one-third of the regular Federal SSI benefit standard.

When an SSI recipient enters a hospital or other medical institution in which a major portion of the bill is paid by Medicaid, the SSI benefit level is reduced to $25. This amount is intended to take care of personal needs, such as hair cuts, newspapers, toilet articles, etc.

State Supplementation

For individuals who had been covered under state OAA programs prior to enactment of the SSI program, federal law requires the states to supplement an SSI recipient's benefits to a level equal to the amount they had been given under OAA. Twenty-five states have mandatory state supplementation.

Most other states provide supplementary payments to SSI recipients. These payments vary from state to state and reflect differences in regional living costs.

Seven states (Arkansas, Georgia, Kansas, Mississippi,Tennessee, Texas, and West Virginia) and the Northern Mariana Islands do not have optional state supplementation.

The state supplement may be issued by the state or the state may elect Federal administration of the state supplement.

If the Federal government administers the State Supplement, applications may be filed with SSA. The Federal benefit standard and the supplement are combined in one check issued by the Federal government.

If the state administers its own supplement, application for the supplement is made at a local welfare office and the supplemental check is mailed separately.

DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF SSI RECIPIENTS

About 4.3 million individuals receive SSI. More than one third (34%), 1.47 million recipients, were eligible on the basis of age; over half (64%), 2.71 million, were eligible on the basis of disability; and 2%, 83,000, were eligible on the basis of blindness.

The proportion of aged, 65 or older, SSI recipients has declined from 61% in January 1974 to 47% in December 1986. Some elderly are counted as disabled if they entered the program before reaching age 65. The number in the dual disabled/aged category has more than doubled during the past ten years.

Of SSI recipients who are eligible based upon age, 39.5% are 80 years and older, compared to 21% of the population 65 years and over who are 80+.

In 1986, **women comprised over three fourths of those entitled to SSI on the basis of age,** and three-fifths (59%) of those entitled on the basis of disability.

Blacks comprise 21% of SSI recipients eligible based upon age, compared to 8% of the total population age 65 and over.

Blacks comprise 28% of SSI recipients eligible based upon disablity.

Persons of Spanish origin comprised 10.5% of the SSI population, with 11.9% of men and 9.7% of the women, being of Spanish origin. (These statistics come from the Current Population Survey, and therefore do not delineate based upon the reason for eligibility).

Over half (57%) of all SSI recipients are women not living with a spouse. Almost three-fourths (72%) of aged SSI recipients are women not living with a spouse, and one-half (50%) of disabled SSI recipients are women not living with a spouse.

Over seventy percent (71%) of aged SSI recipients also receive Social Security benefits. In 1940 less than one percent of recipients of Old Age Assistance also received Social Security.

Almost half (49%) of all SSI recipients also receive Social Security, while only 12 percent had other unearned income, such as veterans pensions and assets, and only 4% had earnings.

Most (76%) SSI recipients live in metropolitan areas. Sixty-five percent of aged recipients reported metropolitan residence, and almost 72 percent of disabled adults reported metropolitan residence.

Approximately 46% of SSI recipients receive state supplementation. (Supplements range from $2 to $292 a month).

PROGRAM PARTICIPATION

Program participation rates have been consistently low throughout the program's history.

A substantial number of persons who are eligible for SSI benefits do not receive them. Estimates confirm that only about 50-60% of the persons eligible for benefits actually receive them.

Social Security Administration (SSA) Outreach

The Social Security Amendments of 1983 mandated SSA to conduct an outreach program to aged people potentially eligible for the SSI program.

1) Beginning in July 1983 SSA established an ongoing effort to notify, by a monthly alert, all Social Security beneficiaries nearing age 65 who are enrolling for Medicare coverage.

2)Between February and June 1984 a one time alert was mailed to 7.6 million beneficiaries who were aged and whose benefits were low enough to indicate possible SSI eligibility.

The results of the one time outreach to 7.6 million aged beneficiaries resulted in 160,000 individuals (2 percent of those alerted) contacting field offices, 79,000 individuals (1 percent of those alerted) applying for SSI benefits and 58,000 individuals (0.7 percent of persons alerted) being awarded benefits.

According to a survey of a sample of the alerted population, individuals indicated that most of those who did not contact SSA after receiving the alert felt that they were ineligible because of excess resources or income.

Recent data still shows little or no understanding of the SSI program.

A July 1986 national survey, commissioned by the Commonwealth Fund Commision on Elderly Living Alone, and conducted by Louis Harris and Associates, revealed that only one-half of all older persons eligible for SSI participated in the program.

The survey showed that only one in five poor elderly is receiving SSI. A unique aspect of the survey was that it attempted to determine why so many older persons were not participants. **When asked why they do not participate, over half of the individuals responded that they had never heard of the program or believed that they were not eligible.**

Possible participation barriers include lack of information or misinformation about eligibility criteria, the inability or unwillingness to to deal with the program's bureaucratic procedures, the negative stigma associated with welfare receipt, the fear of the loss of privacy, and the perception of low benefits.

RECENT IMPROVEMENTS IN SSI

Although there have been numerous legislative changes which have improved the administration of the program, there have been only minor incremental improvements in benefits, with no real change in the eligibility criteria.

There were a number provisions in **Social Security Amendments of 1983 (P.L.98-21) of interest in respect to the SSI program.** 1) Mandated the Secretary of HHS to **notify on a one time basis all elderly OASDI beneficiaries who are potentially eligible,** of the availlibility of SSI; 2) provided an ad **hoc increase in the Fedral benefit standard of $20 for individuals and $30 a month for couples;** 3) **delayed the SSI Cola from July until January,** to keep pace with the Social Security COLA that SSI is based upon; 4) Aged, blind and disabled individuals who are **temporary residents of a public emergency shelter could receive SSI payments for up to three months during any 12 month period;** 5) **disregards emergency and other in-kind assistance provided by nonprofit organizations; 6) amended the federal pass through provisions** which requires states that states maintain their state supplementation **level,** even when there is an increase in the Federal benefit standard due to a cost of living adjustment.

In 1984, P.L. 98-369, (DEFRA) **increased the resource levels over a four year period.** The resource level in 1984 of $1,500 for an individual was increased $100 a year, and by 1989, the level would be $2,000. For a couple the resource level in 1984 was $2,250 and was increased $150 a year, and by 1989 would be $3,000. DEFRA **also limited the rate of recovery for an overpayment** to 10% of the entire benfit SSA was trying to recoup.

The Disability Benefits Reform Act of 1984 provided a **temporary extension of the Section 1619 program.** This program, which was **made permanent by P.L. 99-643, is a work incentive program** designed to motivate potential workers who are currently receiving SSI benefits to find work. The program provides special cash benefit status, continued Medicaid coverage, and eligibility for social services on the same basis as regular SSI beneficiaries for SSI recipients who are working.

Some Proposals for Reform

Raise the Federal benefit guarantee to the poverty level.

Rationale

The SSI program's goal is to set a level of guaranteed income for needy aged, blind and disabled individuals. Unfortunately, the SSI federal benefit level was set, and remains, well below the government's offical poverty guidelines. In 1974, the Federal SSI payment equaled 70 percent of poverty for an individual and 80 percent for a couple. Today, SSI benefits are about 76 percent of the aged poverty line for single persons amd 90 percent of the poverty line for married couples. For the non-aged who receive SSI, benefits are 68 percent of the poverty line for individuals and 79 percent for couples. Even with the state supplement, benefits meet or exceed the poverty line in only 4 states, and two of these states include the cash value of food stamps in the supplements.

Liberalize the Resource Test

Rationale

The 1972 law set stringent limitations on the assets an individual or couple could own and still be eligible for SSI. These limits were $1500 for an individual and $2500 for a couple. In 1984, 12 years after enactment, scheduled increases in the asset levels will bring the level to $2,000 for a single person and $3,000 for a couple by 1989. These limits penalize those aged poor who set aside savings for their retirement rather than just rely on Social Security. The latter provide a cash income which may be supplemented by SSI while the same amount of money, in retirement savings, prevents SSI benefit eligiblity. There are certain exclusions from the asset test, such as the price of one's home, a car, and a burial plot. Since enactment, there has been a doubling of living costs, which has effectively cut in half the value of the allowed assets.

Eliminate one third reduction for living in a house of another

Rationale

If an SSI recipient lives in another individual's house, their SSI benefit level is reduced by one-third, on the theory that this reflects the value of the food and shelter provided to them. This reduction places financial strains on the family, and often discourages them from continuing to provide a home for the beneficiary.

Increase the Personal Needs Allowance

Rationale

When an SSI recipient enters a hospital or other medical institution in which a major portion of the bill is paid by Medicaid, the SSI benefit is reduced to $25. This amount is intended to take care of personal needs such as hair cuts, newspapers, toilet articles. Even though inflation has increased the prices of all of these needs, this amount has not changed since the program's enactment.

Prepared for Chairman Roybal by Lowell Arye, Deputy Staff Director, Subcommittee on Retirement Income and Employment (202) 226-3335. July 1987

RESOLVED:

THAT THE FEDERAL GOVERNMENT SHOULD GUARANTEE ADEQUATE CUSTODIAL CARE FOR UNITED STATES CITIZENS OVER AGE 65.

Reproduced from Brief summary of Older Americans Act programs, by Carol O'Shaughnessy. Washington, Congressional Research Service, 1988. p. 1-3. (CRS Report no. 88-109)

BRIEF SUMMARY OF OLDER AMERICANS ACT PROGRAMS

With the passage of the Older Americans Act in 1965 the Congress created a new Federal program specifically designed to meet the social services needs of older people. Although older persons may receive services under many other Federal programs, the Act is considered to be the major vehicle for the organization and delivery of social services to this group. The Act was reauthorized for 4 years (through 1991) in the 1st session of the 100th Congress (P.L. 100-175). Major programs are the title III program of social and nutrition services grants to States, representing 69 percent of the Act's total FY 1988 funding, and the title V community service employment program, representing 28 percent of total funding.

Title I, Declaration of Objectives, sets out broad social policy objectives oriented toward improving the lives of all older Americans.

Title II, Administration on Aging, establishes the Administration on Aging as the chief Federal agency advocate for older persons and the Federal Council on Aging whose purpose is to advise the President and Congress regarding the needs of older persons. Council members are appointed by the President, the Speaker of the House, and the President pro tempore of the Senate.

Title III, Grants for State and Community Programs on Aging, authorizes grants to State and area agencies on aging to develop supportive and nutrition services, to act as advocates on behalf of programs for older persons, and to coordinate programs for the elderly. The program supports 56 State agencies on aging with funds distributed on the basis of a State's population aged 60 or

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over as compared to all States. It authorizes a wide range of community supportive services, and nutrition services, but most funding is devoted to nutrition services (congregate and home-delivered meals and U.S. Department of Agriculture commodities), representing 68 percent of total title III appropriations. States may transfer funds between their supportive and nutrition services allotments.

In addition to a wide range of supportive services and nutrition services, the law authorizes funds for the following programs: non-medical in-home services for the frail elderly; long-term care ombudsman services; elder abuse prevention activities; health education and promotion services; outreach activities to persons who may be eligible for assistance under the Supplemental Security Income (SSI), Medicaid, and Food Stamp programs; and assistance to older persons with special needs.

The program requires that services be available to all older persons, but targeted on those in greatest social or economic need, with particular attention to low-income minority older persons. Means tests are prohibited; voluntary contributions by older persons toward the costs of nutrition services are permitted by law.

Title IV, Training, Research, and Discretionary Projects and Programs, authorizes the Commissioner on Aging to award funds for training, research, and demonstration projects on aging. Funds are to be used to expand knowledge about aging and the aging process and to test innovative ideas about services and programs for older persons. In past recent years, title IV has supported a wide range of projects, e.g., on community-based long-term care, adult literacy, Alzheimer's disease support services, and career preparation and continuing education in the field of aging.

Title V, Community Service Employment for Older Americans, authorizes funds to subsidize part-time community service jobs for unemployed, low-income persons 55 years and over. Enrollees are paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, and work in a wide variety of community service activities, including health care, senior centers, and education. Funds to operate the program are allocated to eight national organizations and to State agencies.

In recent years national organizations have received 78 percent of funds and State agencies 22 percent. In program year 1987-88 (July 1, 1987-June 30, 1988) title V supports about 66,000 job slots.

Title VI, Grants to Native Americans, authorizes funds for social and nutrition services to older Indians and native Hawaiians. Funds are awarded directly to tribal organizations by the Commissioner on Aging. For FY 1987, 133 tribes received funds. Funds are available to native Hawaiians when total title VI funding exceeds the FY 1987 appropriated levels.

Reproduced from Older Americans Act amendments of 1987: a summary of provisions, Public Law 100-175; an information paper prepared for use by the Special Committee on Aging, U.S. Senate. Washington, G.P.O., 1987. p. 1-5.

OLDER AMERICANS ACT AMENDMENTS OF 1987: A SUMMARY OF PROVISIONS

Public Law 100-175

I. INTRODUCTION

A. OVERVIEW

Authorizations of appropriations for the Older Americans Act of 1965, as amended, expired at the end of fiscal year 1987. Public Law 100-175, the Older Americans Act Amendments of 1987, providing a 4-year reauthorization, through 1991, was enacted on November 29, 1987.[1]

The amendments contained no major overhaul of the Act; however, a number of new provisions significantly expanded certain service components of the State and area agency on aging program under title III to address the special needs of certain populations. These include the frail elderly living at home; residents of long-term care facilities; persons at risk of abuse, neglect, or exploitation; and low-income elderly who may be eligible for, but are not receiving, benefits under other Federal programs. Prior to the enactment of Public Law 100-175, the Older Americans Act contained three separate authorizations of appropriations for supportive services, congregate nutrition services, and home-delivered nutrition services. In the new law, Congress authorized six additional distinct authorizations of appropriations for services under title III. These are: In-home services for frail older individuals; long-term care ombudsman services; assistance for special needs; health education and promotion services; services to prevent abuse, neglect, and exploitation of older individuals; and outreach activities for persons who may be eligible for benefits under the Supplemental Security Income [SSI], Medicaid, and Food Stamp programs. Although State and area agencies on aging have had some responsibilities to address these service areas in the past, there were no separate authorization levels under title III to carry out these responsibilities. The authorization of supportive services funds was considered a generic category intended to address a very broad range of social services needs. While the intensity of activities of State and area agencies on aging in these areas is to be enhanced with the creation of the new funding authorizations, Congress also sought to protect the existing Older Americans Act programs through a provision stating that funds for the new authorizations may not be appropriated unless total appropriations for programs in effect in fiscal year 1987 increase by at least 5 percent over the previous year. This so-called funding "trigger" does not, however, apply to the new authorization for in-home services for the frail elderly; the trigger is effective through fiscal year 1990.

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[1] The House version of the amendments, H.R. 1451, was introduced by Rep. Kildee on March 5, 1987, and was ordered reported to the House by the Committee on Education and Labor on May 12 (House Report No. 100-97). The bill was approved with amendments by the House on May 28. S. 887, the Senate version of the amendments, was introduced by Senator Matsunaga on March 31, and was ordered reported to the Senate by the Committee on Labor and Human Resources on July 22 (Senate Report No. 100-136). The Senate passed S. 887 on August 6. The Conference Report was filed in the House on Nov. 9 (House Report No. 100-427), was approved by the Senate on Nov. 12 and by the House on Nov. 17.

In addition to the groups mentioned above, other groups given special attention in various amendments to the Act were Native Americans and the disabled. With respect to Native Americans, the law required the Commissioner on Aging to establish within the Administration on Aging [AoA] a new Office for American Indian, Alaskan Native, and Native Hawaiian Programs to be headed by an Associate Commissioner. The special needs of older Indians are to be addressed by a permanent interagency task force to focus on issues of service coordination and improvement for this group. In addition, other amendments were enacted to liberalize eligibility requirements for Indians to receive assistance under the Act. The law also recognized the special service needs of Native Hawaiians by creating a separate authorization of funds for this group under title VI which formerly provided funding only for Indian tribal organizations. Another provision authorizes funding for employment services under the community service employment program to national Indian aging organizations and national Pacific Island and Asian American aging organizations.

With respect to the disabled, the amendments included provisions to improve coordination of the State and area agency on aging program with other service systems established specifically to serve the disabled. An amendment to the elderly nutrition program allows nutrition project administrators to offer meals to disabled individuals who reside at home with and accompany older persons eligible for nutrition services. Another amendment authorizes the Commissioner to conduct demonstration projects to coordinate the State agency on aging long-term care ombudsman program with the State protection and advocacy systems for the developmentally disabled and the mentally ill.

In addition to amendments addressing the needs of these identified elderly groups, the law also reemphasized prior law requirements to focus the Act's resources on those older persons who are in the greatest economic or social need of assistance, with particular attention on low-income minority older persons. A series of amendments strengthened prior law stipulations by requiring that the needs of these groups be incorporated into planning, outreach, and service delivery activities of State and area agencies.

The law also added new provisions to strengthen, expand, or clarify administration and/or delivery of various service programs under the Act. In this regard, the amendments included provisions to: Protect the confidentiality of clients who receive legal assistance; strengthen the administration of the State long-term care ombudsman program and afford ombudsmen certain protections in the performance of their duties on behalf of long-term care facility residents; increase the access of older persons to information about post-secondary educational opportunities; enhance a variety of volunteer opportunities for older persons; and authorize demonstration projects to protect consumers of home care services. The law also required State agencies on aging to set minimum dollar amounts to be spent by area agencies on aging for access, in-home, and legal assistance services. These areas have been identified as priority services under the State and area agency on aging program.

The law also addressed the effect that participation in the community service employment program under title V of the Act has on eligibility for certain other Federal programs. Under prior law, wages received under the title V program could be counted as income when determining eligibility for Federal housing and Food Stamp programs. Public Law 100–175 liberalized these eligibility requirements by enacting a provision to exclude title V wages from being considered as income when determining benefits under these programs.

In other areas, a number of amendments addressed issues relating to the administration of Older Americans Act programs, including the organizational status of AoA within the Department of Health and Human Services [DHHS]. This issue has been a recurring one during previous Older Americans Act reauthorizations due to concern by some that AoA because it is located within the Office of Human Development Services [OHDS], does not have the visibility to effectively advocate on behalf of the elderly across a broad range of issues. The 1987 amendments addressed this concern by elevating the status of the Commissioner on Aging within the DHHS structure. The law did this through an amendment requiring that the Commissioner report directly to the Secretary of DHHS rather than, as under prior law, to the Office of the Secretary.

Other amendments relating to the administration of the program by AoA required improved data collection on programs and services funded under the Act and required the Commissioner to publish an annual statement of goals and objectives of AoA. The law also increased the allowable amount of funds to be spent on the administration of area plans on aging and of community service employment projects; required public hearings on activities under State and area plans on aging; and addressed the organizational status of area agencies on aging when they are located within umbrella organizations.

In addition to reauthorizing and amending the Older Americans Act programs, Public Law 100–175 included a number of other provisions affecting the elderly. The law authorized the President to call a White House Conference on Aging in 1991; authorized adult day care centers for the elderly and the chronically impaired disabled to receive funds for meals under the National School Lunch Act; required the Secretary of Labor to develop a consumer price index for older persons; authorized the National Institute on Aging to conduct clinical trials to test the efficacy of certain drugs on treatment of Alzheimer's disease; and authorized the Public Health Service to conduct demonstration projects on home health services for low-income persons in need of skilled medical or related health services, and for victims of Alzheimer's disease and their families.

B. AUTHORIZATION LEVELS

Table 1 presents authorization levels for the Older Americans Act in fiscal year 1987 and authorization levels for programs which were reauthorized or newly created by Public Law 100-175. The new law increased fiscal year 1988 authorization levels by 5 percent above fiscal year 1987, except for the title VI program of grants to Native Americans (formerly called Grants for Indian Tribes). Fiscal year 1988 authorizations for that program were increased by 56 percent above the fiscal year 1987 level, and the program was expanded to provide funding for a new Native Hawaiian program. The title VII older Americans personal health education and training program was repealed.

TABLE 1.—OLDER AMERICANS ACT AUTHORIZATION LEVELS, FISCAL YEARS 1987–91

[In thousands of dollars]

Act title	1987 [1]	1988 [2]	1989 [2]	1990 [2]	1991 [2]
Title II					
Federal Council on the Aging	$200	$210	$221	$232	$243
Title III					
Grants for State and community programs on aging:					
Supportive services and centers	361,500	379,575	398,554	418,481	439,406
Nutrition services	614,600	645,130	684,837	727,778	773,017
Congregate	(395,000)	(414,750)	(435,488)	(457,262)	(480,125)
Home delivered	(75,600)	(79,380)	(83,349)	(87,516)	(91,892)
USDA commodities	(144,000)	[3] (151,000)	[3] (166,000)	[3] (183,000)	[3] (201,000)
In-home services for frail elderly	(4)	25,000	26,250	27,563	28,941
Assistance for special needs	(4)	[5] 25,000	[5] 25,000	[5, 6] such sums	[5, 6] such sums
Health education and promotion	(4)	[5] 5,000	[5, 6] such sums	[5, 6] such sums	[5, 6] such sums
Elder abuse prevention	(4)	[5] 5,000	[5, 6] such sums	[5, 6] such sums	[5, 6] such sums
Long-term care ombudsman	(4)	[5] 20,000	[5, 6] such sums	[5, 6] such sums	[5, 6] such sums
Outreach for SSI, Medicaid, and food stamps	(4)		[5] 10,000	[5] 10,000	
Title IV					
Training, research, and discretionary projects and programs	31,400	32,970	34,619	36,349	38,167
Home care demonstration projects	(4)		[5] 2,000	[5] 2,000	
Ombudsman and advocacy demonstration projects	(4)		[5] 1,000		
Title V					
Community service employment for older Americans	[7] 368,300	386,715	406,051	426,353	447,671
Title VI					
Grants for Native Americans	[8] 8,600	[9] 13,400	[9] 16,265	[9] 19,133	[9] 22,105
Part A—Indian program		(12,100)	(14,900)	(17,700)	(20,600)
Part B—Native Hawaiian program	(4)	(1,300)	(1,365)	(1,433)	(1,505)
Title VII					
Older Americans personal health education and training program	[6] such sums	(10)	(10)	(10)	(10)
Total	[11] 1,384,600	[11] 1,538,000	[11] 1,604,797	[11] 1,667,889	[11] 1,749,550

[1] Public Law 98–459.

[2] As contained in Public Law 100–175.

[3] The law requires the Secretary of Agriculture to maintain a reimbursement level of 56.76 cents per meal for FY 1986–91.

[4] Not authorized.

[5] The law requires that total appropriations for programs funded in FY 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.

[6] Such sums as may be necessary.

[7] Plus such additional sums as may be necessary to maintain at least 62,500 employment positions.

[8] These funds were authorized for grants to Indian tribes. Under the law in effect in FY 1987, this title was called Grants for Indian Tribes.

[9] The law creates a separate Part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for Part A, the Indian Program, and for Part B. The law further specifies that Part B receive funding only if the total appropriations for title VI exceed the FY 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the FY 1987 level, and half of any increase above the first $250,000 up to the authorized amount.

[10] This title is repealed.

[11] Plus such sums as may be necessary for certain programs.

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Reproduced from U.S. Congress. House. Select Committee on Aging. Subcommittee on Human Services. Exploding the myths: caregiving in America; a study. Washington, G.P.O., 1987. p. 51-58.

IV. INFORMAL CAREGIVING: THE ROLE OF THE PUBLIC AND PRIVATE SECTOR

The major issue confronting policymakers concerned about the long-term care needs of an aging population is how to design, finance and implement a system of formal care which supports and complements the array of services already being provided by informal caregivers. This is a complex problem, one which has generated much debate in recent years about the nature and direction of policies and programs to be developed.

Status of Current Public Policies

At the present time, informal caregivers provide the bulk of long-term care services to their elders with little support from public programs. For example, both the Medicare and Medicaid programs have a strong institutional bias, Medicare toward hospital reimbursement and Medicaid toward reimbursement for nursing home care. Only those Medicare beneficiaries who are confined to their homes and need skilled nursing care on a part-time or intermittent basis are eligible for home health care services provided by a Medicare-certified agency. There are no provisions for personal or custodial care, the type and level of care most frequently needed by frail and/or chronically disabled elderly persons.

Under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, states are allowed to request Medicaid waivers from the Health Care Financing Administration in order to provide home and/or community-based services to impaired elders. States must demonstrate that the costs of such services do not exceed the costs of comparable care in a nursing home. As of April 1986, 46 states had received approval for waivers to cover personal care, respite care and other noninstitutional services. While these waivers have the potential to make home and community-based services available to elders and their families, few programs are statewide.

The Federal government also provides funds for noninstitutional services through Title III of the Older Americans Act (OAA). In-home care, such as homemaker, home health aide and chore services, is a priority service, Under the OAA, home-delivered meals also have grown in importance. The ability of the OAA to complement the efforts provided by informal caregivers is limited, however, due to its relatively small level of resources as compared to other programs. The Social Services Block Grant also provides limited funds for community-based services designed to prevent or reduce inappropriate institutionalization.

Certain provisions in current public policies may have the unintended consequence of creating disincentives for families to provide care to their disabled relatives. A prime example of such impediments is the requirement of the Federal Supplemental Security Income program (SSI) that elders living in the household of another individual or family must receive a one-third reduction in monthly benefits. This provision serves as a disincentive to families who want to care for a disabled person in their homes.

Another example is the Medicare home health care regulation which restricts coverage to intermittent care, thereby discouraging families from paying for supplemental services. That is, if the family chooses to pay for additional hours of nursing care not covered by Medicare, then the care may not be deemed intermittent and Medicare can deny all home health care benefits.

Two provisions in H.R. 3838, the Tax Reform Act of 1986, also represent potential disincentives for family care. Under the old law, an impaired elderly person could claim a personal exemption while at the same time being claimed as a dependent on another taxpayer's (e.g., daughter or son) return. According to the new law, the personal exemption is no longer allowed when an elderly individual is claimed on another taxpayer's return. In addition, the increase in the floor under the medical expense deduction from 5 percent to 7.5 percent of the taxpayer's adjusted gross income will make it more difficult for families to claim the Child and Dependent Care Credit. The change in the medical expense deduction provision will require the caregiver to spend more resources for the medical care of an elderly dependent in order to be eligible for the credit.

Public Sector Support for Informal Caregivers

As policymakers begin to recognize the pivotal role of the family, friends and neighbors in helping to maintain disabled elderly persons at home, they are exploring a number of service options and financial strategies to bolster the informal care system.

Service Strategies

Public policies can promote informal caregiving by supporting the development of services targeted to family members and other unpaid helpers who assist impaired elderly persons. These services run the gamut from support groups, counseling and training programs to subsidized respite care.

The little information which is available on service utilization indicates that families tend to purchase services only when the responsibility of elder care becomes too difficult for them to handle alone or with additional unpaid help. Further, when they do approach formal service providers, they are modest in their service demands, often requesting far less assistance than professionals would have recommended. Thus, the fear expressed by many policymakers that families will "come out of the woodwork" if services are made available is largely unfounded.

There is concern among policymakers that policies aimed at providing formal services to caregivers and care recipients may encourage caregivers to substitute paid care for informal care. Few studies have examined this "substitution effect"; however, the existing research has found little evidence to substantiate this concern (Gonyea et al., 1982; Sklar and Weiss, 1983).

Some have suggested that the provision of formal services in selected areas may allow caregivers to focus their attention on other care needs which they are better equipped to handle (Greene, 1983; Litwak, 1985). In a study of a random sample of disabled older persons and their caregivers in eastern Massachusetts, McKinlay and Tennstedt (1986) found that families using formal services provided the same amount of help but in different areas. Other researchers examining the impact of the use of homemaker services on the provision of informal care in New York (Frankfather et al., 1981) found that families tend to shift their responsibilities to other activities which complement homemaker chores.

The degree to which substitution is judged as desirable or undesirable depends upon the goal of the formal service program which is being implemented. If the major objective is to provide supportive services to informal caregivers, then substitution would be considered undesirable. If, on the other hand, formal services are designed to provide respite to the informal caregiver to alleviate burden, then substitution may be a desired outcome. In the long run, the substitution of formal for informal care may be seen as beneficial if it results in the delay or prevention of costly institutionalization of the elderly care recipient.

1. Support Groups

Support groups have proliferated in response to the growing recognition that families need to acquire and/or sharpen their coping skills in order to deal with the long-term demands of a chronically disabled elderly relative. These peer programs (e.g., the Alzheimer's Disease and Related Disorders Association) have emerged primarily at the grass roots level as caregivers themselves have come to realize that their best coping mechanism is the sharing of experiences. Recent Federal and state legislative initiatives have encouraged the further development of these programs.

2. Counseling, Education and Training

Counseling, education and training programs also have received public sector support. They are designed to help families cope with conditions (e.g., behavioral disturbances, incontinence) which have been identified as precipitating factors in the decision to institutionalize a disabled elderly individual. While there have been few systematic evaluations of these programs, the evidence suggests that counseling, training and education have been successful in helping families to cope with the problems posed by stroke (Mykyta et al., 1976) and Alzheimer's disease (Lazarus et al., 1981).

3. Respite Care Services

Numerous studies indicate that respite care is the preferred service intervention for helping to alleviate caregiver burden. Respite care refers to the short-term, substitute care provided in or outside the home on behalf or in the absence of the primary caregiver for the purpose of offering a period of relief from the constant care of a chronically disabled elderly individual. While the services are intended to assist the frail and/or disabled elderly person, the primary beneficiary is the informal caregiver.

Respite care programs vary with respect to setting, duration, level of care and staffing patterns. Care is provided in the home, in community-based centers (e.g., senior citizen centers, adult day care centers) and in institutions (e.g., personal care homes, nursing homes, hospitals). The length of service ranges from a few hours per day or week, to overnight care to several days or weeks per episode. Moreover, care can be provided by volunteers or paid staff, although much lower levels of care (i.e., companion and chore services) are generally offered by the former.

The Federal and state governments have supported several demonstrations which have examined the feasibility of different respite care models. To date, however, most of the evaluative information about respite care programs has been based on ancedotes or descriptive analyses of small, non-representative samples. Therefore, little is known about attitudes toward and the demand for respite care by caregivers, the role of respite care in reducing caregiver burden, and the importance of respite services in deterring or postponing the decision to institutionalize an impaired elderly family member.

Financial Strategies

There are a number of financial assistance programs currently available in the public sector which are designed to support family members caring for an impaired elder. The major strategies are direct payments to informal caregivers for their services rendered to an aged individual and tax allowances. The money received through cash grants or tax allowances can be used at the discretion of the family to purchase services or to cover other expenses that would ordinarily be out-of-pocket. Economic programs may be seen as ways to offset the costs of certain foregone opportunities such as the loss of wages or free time for personal errands. Tax subsidies are particularly appealing because they do not require the establishment of specific Federal or state programs to administer the benefits.

The financial incentive approach assumes that there is a demand for economic assistance. In fact, as was noted previously, findings from numerous studies indicate that financial burden is reported by a minority of caregivers. Further, when asked to choose between financial and service options, services are overwhelmingly preferred over economic assistance.

The financial approach also assumes that there is a market of services which are accessible and available for purchase. In reality, community-based long-term care tends to reflect a fragmented patchwork of programs, with little coordination and limited accessibility in many geographic areas. Despite these limitations, however, proponents of financial strategies emphasize the flexibility these programs afford caregivers in arranging for the care of an elderly care recipient.

1. Cash Payments

A recent national survey of state agencies (Linsk et al., 1986) found that 35 states permit some form of payment to relatives for the provision of home care to elderly clients. This financial incentive usually is restricted to clients at very high risk of institutionalization. Some programs grant the aged person total discretion in hiring a caregiver. In states which supplement the Federal SSI benefit, elderly care recipients may be permitted to use this supplement to reimburse a caregiving relative. On the opposite end of the continuum, selected programs are designed to protect the interests of the client by, for example, restricting reimbursement to only those relatives who are licensed care providers.

Among the 15 states with no payment to family caregivers, the most frequently cited reason is the Federal Medicaid regulation prohibiting the payment of relatives through the definition of Personal Care Services. Several agencies also note their state's own prohibition as a reason for disallowing payments to relatives.

2. Tax Allowances

Caregiving taxpayers have access to three mechanisms in the Federal income tax system: the exemption, the deduction and the tax credit (Burwell, 1986). The primary tax allowance available to households with elderly dependents is the Child and Dependent Care Credit. Under the Economic Recovery Tax Act of 1981, expenditures for the noninstitutional care of a disabled spouse or other dependent were considered eligible for the credit.

The tax credit is restrictive, however, in that the caregiver and elderly dependent must meet the following criteria:

1) the dependent must spend at least eight hours daily in the taxpayer's home;

2) the dependent must be physically or mentally incapable of caring for him or herself;

3) all taxpayers in the household must be gainfully employed; and

4) only expenses up to a maximum of $2,400 per dependent are eligible for the credit.

The credit is progressive in that individuals with lower incomes can claim a higher percentage of their dependent care expenses than persons with higher incomes. However, the credit is not refundable; that is, the amount of the credit cannot exceed the total tax liability of the taxpayer. Consequently, many low-income households are ineligible.

In fact, according to the criteria specified above, the majority of the two million caregivers represented in the 1982 Long-Term Care Survey would not be eligible for this tax credit. That is, only one-third are employed and one-quarter do not live with the care recipient. There have been several legislative proposals in Congress which would loosen the current restrictions on the existing Dependent Care Tax Credit. The broadest proposal would not require elderly dependents to be functionally impaired in order for family members to claim the credit. Others would eliminate the employment criterion and/or the shared household requirement or offer those eligible more financial support.

Since 1979, four states have legislated tax allowances for family caregivers (Burwell, 1986). Oregon provides for a tax credit of up to 8 percent of expenses for the care of an elderly dependent (maximum credit of $250) in households with incomes below $17,500. Idaho allows households that maintain an elderly relative and provide for over one-half of the support to take a standard deduction of $1,000 or a refundable tax credit of $100. Iowa permits taxpayers to deduct from their income up to $5,000 in expenses attributable to the care of an elderly dependent living in the same household; the care recipient, however, must be a Medicaid enrollee or Medicaid eligible. Arizona permits taxpayers to deduct eligible medical expenses for an elderly person living in the state; eligibility is not restricted to relatives. This benefit recognizes the migration of elders to Arizona, many of whom are being cared for by friends and neighbors in the absence of family.

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II. BACKGROUND

A. Description of Adult Day Care Services

1. Definition of Adult Day Care and Its Relationship to Other Community-Based Long-Term Care Services

There is no federally recognized definition of day care. Because it is supported by a variety of Federal funding sources primarily administered by States, State agencies responsible for day care services have developed definitions for the operation of their day care programs. Generally, day care services include a variety of health and social services offered to chronically ill or disabled individuals in a group setting and on a part-time basis in order to assist them in retaining or attaining maximum physical and mental well-being. This kind of care is supported by the view that individuals in need of medical, health, and/or health-related social services should be served in the community rather than an institution, to the greatest extent possible. The services which may be included in a day care program are: assessment of client needs; health monitoring; skilled nursing services; physical, occupational, and speech therapies; personal care, such as assistance with walking, grooming, bathing, etc.; nutritional services; counseling; and transportation.

The term "adult day care" is a generic one because of the variety of health and social services offered through a day care program. Various terminology is used to describe this service--adult or geriatric care, therapeutic day care, day treatment services, day health care, senior improvement services, or day hospital care. The purpose, organization, kinds of participants, setting, program content and structure may differ among programs. Depending on the needs of the participants, the care provided at a day care center may range from active rehabilitation for patients in a post-acute phase of an illness to the provision of one or more health or health-related social services for the chronically disabled.

Although there is no federally recognized definition of adult day care, the National Institute on Adult Daycare (NIAD), a division of the National Council on the Aging (NCOA) representing the interests of adult day care providers in the United States, developed a definition as part of a project to develop standards for day care providers. According to these standards,

> Adult day care is a community-based program designed to meet the needs of functionally impaired adults through an individual plan of care. It is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective setting during any part of a day but less than 24-hour care.
>
> Individuals who participate in adult day care attend on a planned basis during specified hours. Adult day care assists its participants to remain in the community, enabling families and other caregivers to continue caring for an impaired member at home. 1/

The Department of Health, Education, and Welfare (HEW), when setting up day care demonstration projects authorized by the Social Security Amendments of 1972, defined adult day care with a specific health service orientation as follows:

> [those services] provided under health leadership in an ambulatory care setting to adults who do not require 24-hour institutional care but who are incapable of full-time independent living due to physical or mental impairments and which . . . satisfy the participants' health maintenance and restoration needs, including socialization elements to overcome isolation often associated with illness in the aged and disabled. 2/

1/ National Institute on Adult Daycare (a constituent unit of the National Council on the Aging). Standards for Adult Day Care. Washington, National Council on the Aging, 1984. p. 20.

2/ U.S. Department of Health, Education, and Welfare. Experimental Day Care Programs: Research Grants and Contracts. Federal Register, v. 41, no. 6, Jan. 9, 1976. p. 1604.

Adult day care services are one component of the long-term care continuum which stretches from full institutionalization to the provision of one or more medical, health and/or health-related social services to older and disabled persons in the community. Day care may be described as one means of bridging the gap between the institution and the community. Although the service components which constitute a day care program are not new services, day care is a different way to organize existing medical, health and/or health-related social services. It differs from out-patient clinic services by offering more and extended visits and a wider range of services. Furthermore, it may offer a broader range of therapeutic services than are normally available in most senior centers. 3/

3/ U.S. Department of Health, Education and Welfare. Administration on Aging. Adult Day Care Services: Concept and Financing Sources. AoA-TA-77-2. Oct. 4, 1976. Washington, 1976. p. 2-3.

RESOLVED:

THAT THE FEDERAL GOVERNMENT SHOULD GUARANTEE LONG-TERM HEALTH CARE FOR UNITED STATES CITIZENS OVER AGE 65.

Reproduced from U.S. Congress. Senate. Special Committee on Aging. Developments in aging: 1986, volume 1; a report pursuant to S. Res. 353, SEC. 19, Mar. 13, 1986 resolution authorizing a study of the problems of the aged and aging. Washington, G.P.O., 1987. p. 261-286. (Report, Senate, 100th Congress, 1st session, no. 100-9, volume 1)

Chapter 8

LONG-TERM CARE

OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private medigap insurance. Many elderly persons and their families pay the full costs out-of-pocket, making long-term care the single greatest threat to the financial security of older Americans.

Neither significant public nor private improvements in long-term care financing and delivery are on the immediate horizon. The reluctance to implement new long-term care initiatives can be attributed to three factors. First, the 6 million older Americans who need long-term care are a relatively new phenomenon—with no tradition to help mobilize congressional interest or action. Second, the enormous costs of improving access to long-term care services for the elderly tend to deter interest in comprehensive legislative reform. Third, no current consensus exists on the best way to finance long-term care.

But the need for improvement in long-term care has grown more pressing. During the past 2 years, a series of hearings held by the Senate Special Committee on Aging disclosed a new and troublesome trend. It was determined through these hearings that Medicare beneficiaries are being discharged from hospitals "sicker and quicker," in large part because of the implementation of the Medicare prospective payment system [PPS]. More importantly, these sicker beneficiaries are being discharged into the already strained long-term and subacute care system. Therefore, many Medicare beneficiaries are not able to obtain the continued care they often need after hospital discharge.

Federal initiatives to provide long-term care are lacking. The theory behind implementation of PPS was that patient length of stay in costly hospitals would be decreased and that greater amounts of less costly continued care would be provided in the home or nursing home setting. This substitution is occurring, but the Health Care Financing Administration [HCFA] under the Department of Health and Human Services [DHHS] appears to be limiting reimbursement for those substitute services. In the face of enormous Federal deficits, few observers expect the Congress to tackle a major new long-term care initiative in the near term.

In early January 1987, Secretary of DHHS Dr. Otis Bowen testified before the Senate and House Aging Committees on his proposal for catastrophic illness coverage. The President, in his 1986

State of the Union Address, specifically charged DHHS with the task of drafting such a proposal.

Secretary Bowen's proposal would use an expanded Medicare part B to cover catastrophic hospital costs for the elderly and a combination of State and private initiatives to meet these acute care costs for the rest of the population. Various tax incentives, such as Individual Medical Accounts [IMA's] were the primary financing vehicles for long-term care needs.

The biggest weakness in the Bowen proposal is the limited set of options the Secretary offers for long term care. His recommendations for tax credits, such as the IMA's, by emphasizing institutional settings, invite care that is more expensive, perhaps inappropriate, and even less desirable than care in a home or community. These long-term care incentives, further, rely too heavily on solutions that are unlikely to help lower-income and even middle-income individuals and families.

Bowen's proposal also would not really expand coverage beyond current services under Medicare for the aged. For example, prescription drugs would remain an out-of-pocket expense. Providing catastrophic hospital coverage through an additional part B premium would not ensure access to coverage for those low-income individuals who do not get Medicaid and who cannot afford the added cost.

Secretary Bowen's proposal, despite its limitations, successfully focused congressional attention on the issue of catastrophic health care costs and will serve as a backboard off which to bounce more comprehensive solutions.

Private initiatives alone are unlikely to solve more than a small portion of the problem. The experience of private insurers to date has been disappointing. Long-term care insurance policies have not caught on with the American public, especially among those young enough to purchase insurance when it is more affordable. Employers, too, have shown a reluctance to offer a new long-term care benefit, though there are now available several group plans offered by insurance companies.

A. BACKGROUND

1. Types of Long-Term Care

The phrase "long-term care" encompasses a wide array of services offered in a variety of settings ranging from institutional settings (e.g., nursing homes) to noninstitutional settings (e.g., adult day care centers and a person's own home). Community-based long-term care typically encourages a variety of noninstitutional health and social services such as home health care, homemaker, chore and personal services, occupational, physical and speech therapy, adult day care, respite care, friendly visiting, and nutritional and health education.

Long-term care services incorporate the needs of two different types of patient. Some long-term care services meet the health care needs of subacute patients who have recently been discharged from a hospital, while other patients with chronic conditions require care in a nursing home or other facility for an extended period of time.

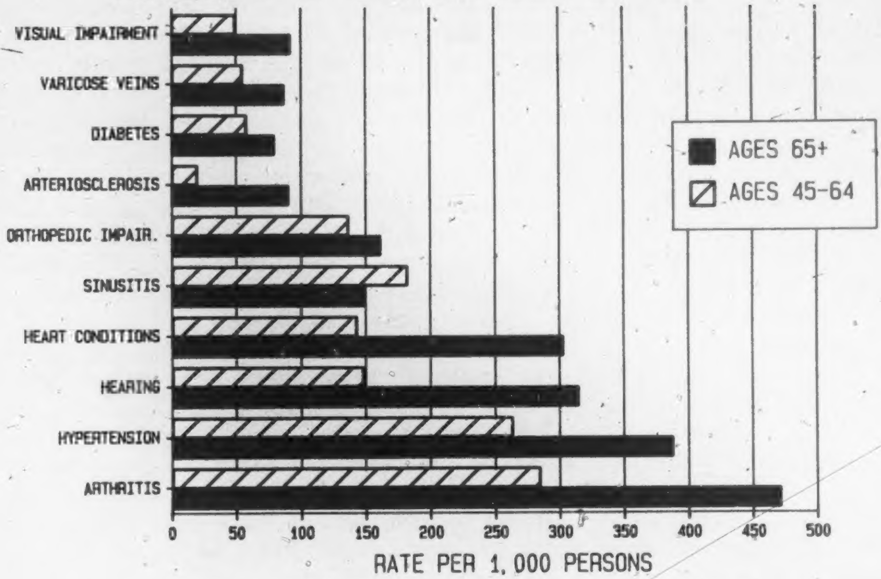
Access to long-term care by discharged patients is a growing problem. In hearings before the Senate Special Committee on Aging, it has been established that while the prospective payment system is causing Medicare patients to be discharged sooner and sicker from hospitals, too often, these patients do not have access to needed home health and skilled nursing care. While the problem of access to needed post-hospital care is not new, it has worsened under the incentives of the prospective payment system.

The second category of long-term care patients is the more traditional patient: Those with functional disabilities, mental disorders, and other nonacute ailments that require maintenance or custodial care over long periods of time. Long-term care for those patients is characterized by extended medical, personal, social, and psychological care at home or in institutions. The need for long-term care coincides not with particular medical diagnoses, but rather with chronic physical or mental disabilities that impair functioning.

Chronic conditions are problems of aging and, as such, are responsible for a large portion of the Nation's health expenditures. More than four out of five persons 65 and over have at least one chronic condition and multiple conditions are commonplace in the elderly. However, most older persons are able to live independently in spite of these conditions. According to the 1982 data from the National Long-Term Care Survey, about 19 percent of older persons living in the community report that they can no longer carry on normal activities because of chronic conditions. In the 1982 population of persons over age 65, the leading chronic conditions were arthritis, hypertensive disease, hearing impairments and heart conditions. (See Chart 8–1).

CHART 8-1

PREVALENCE OF TOP TEN CHRONIC CONDITIONS: 1983



SOURCE: National Center for Health Statistics, Division of Health Interview Statistics

A significantly higher proportion of persons age 65 and older than persons under age 65 are limited in their abilities to perform normal daily activities due to a chronic condition. As shown in chart 8-2, it is those over age 75 who are most hindered by chronic conditions.

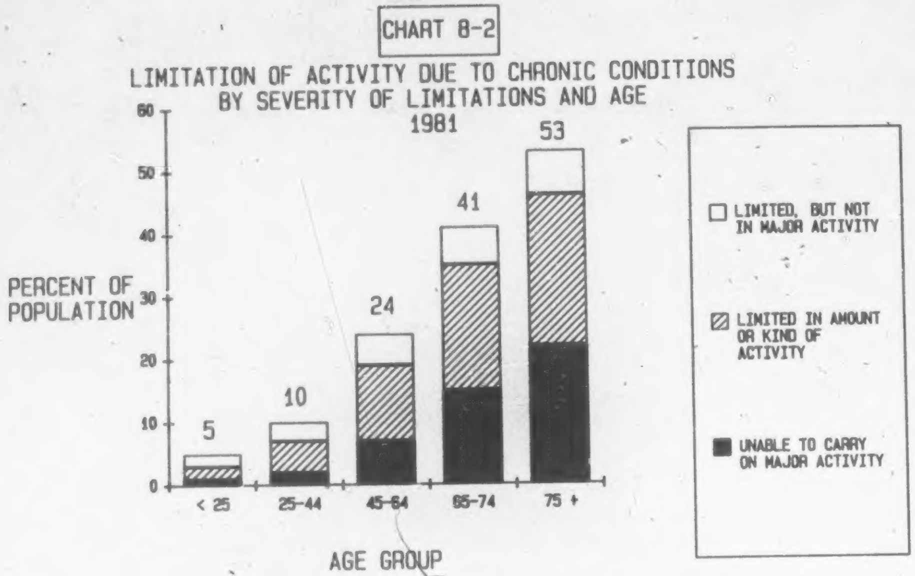


CHART 8-2

LIMITATION OF ACTIVITY DUE TO CHRONIC CONDITIONS
BY SEVERITY OF LIMITATIONS AND AGE
1981

SOURCE: National Center for Health Statistics,
1981 Health Interview Survey, unpublished

2. NUMBERS OF PEOPLE RECEIVING LONG-TERM CARE

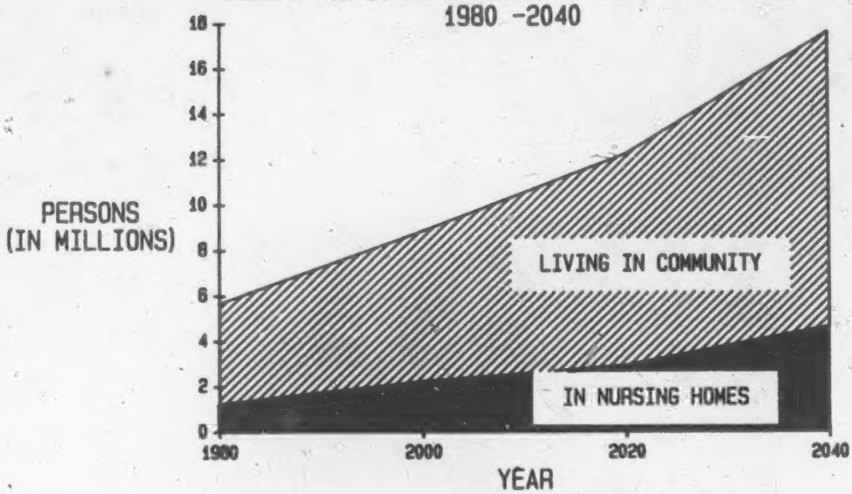
(A) NURSING HOME CARE

In 1985, nearly 12 million elderly citizens had some degree of limitation of daily activity due to chronic conditions, but only an estimated 1.5 million older Americans were confined to nursing homes. Between 1985 and 2000, this population is expected to increase by 47 percent, to 2.2 million people, and then double to 4.4 million between the years 2000 and 2040.

Chronic illness can prevent individuals from functioning independently without assistance. For those over 65 with a chronic condition in 1985, an estimated 5.2 million persons required some assistance in performing the activities of daily living to maintain independence. This figure is expected to reach 7.2 million by the turn of the century, 10.1 million by the year 2020, and 14.4 million by 2050. Other groups requiring some measure of long-term care include the mentally retarded, the developmentally disabled, and the adult chronically mentally ill.

CHART 8-3

OLDER AMERICANS IN NEED OF LONG-TERM CARE
1980 -2040



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

A large proportion of noninstitutionalized older Americans may be in need of more extensive long-term care than they receive in the community. According to the National Center for Health Statistics, 2.1 million of the noninstitutionalized elderly need help in one or more basic physical activities (getting in and out of bed, dressing, eating, bathing, using the toilet) and 2.4 million elderly need the help of another person in carrying out home management activities. In addition, approximately 425,000 of the noninstitutionalized elderly usually stay in bed all or most of the time because of a chronic health problem.[1]

For some of these very dependent people, the nonavailability of beds is a factor preventing their placement in nursing homes. While there are no firm nationwide estimates of the potential needed supply of nursing home beds, experts agree that there are serious shortages of beds throughout the country, with estimates ranging into the hundreds of thousands. Certain localities report a short supply of beds as measured by the numbers of long-term care patients backlogged in acute care hospitals awaiting discharge to a nursing home.

Although only 5 percent of all older Americans are likely to be in a nursing home at any given time, that likelihood increases with age. In 1985, an estimated 2 out of every 100 persons in the 65 to 74 age group, 7 out of 100 persons in the 75 to 84 age group and about 16 out of 100 persons in the 85-plus age group were in a nursing home on any given day.[2] With rapid growth in the oldest age group will come increased demands for nursing home care.

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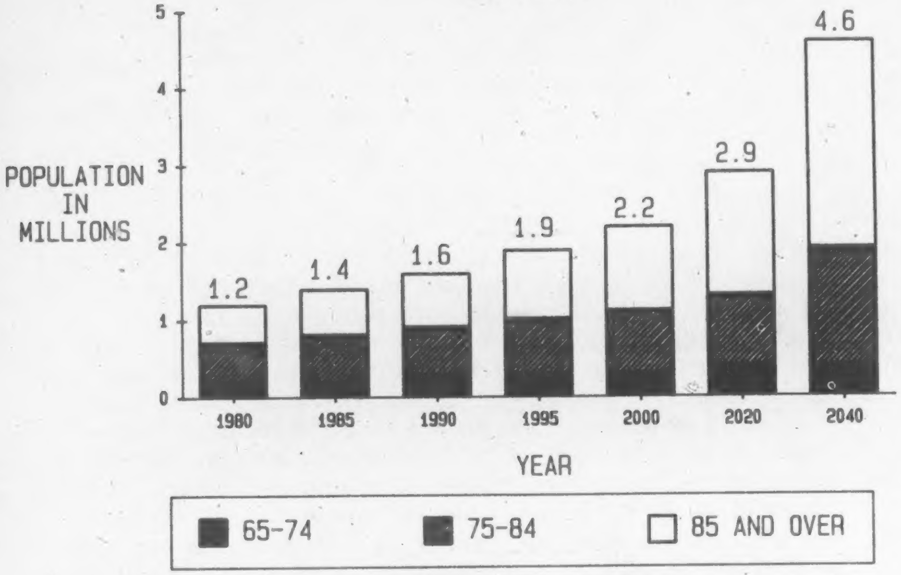
[1] National Center for Health Statistics, 1977 National Nursing Home Survey.

CHART 8-4

NURSING HOME POPULATION PROJECTIONS
PERSONS 65 YEARS AND OLDER BY AGE GROUP
1980-2040



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

(B) HOME HEALTH CARE

For every person 65 years of age and over residing in a nursing home there are nearly four times as many living in the community requiring some form of long-term care. The 1982 National Long-Term Care Survey estimated that approximately 4.6 million noninstitutionalized elderly Americans—about 19 percent of the over 65 population—had limitations in activities in daily living [ADL's] and instrumental activities of daily living [IADL's]. Limitations in ADL's reflect dependence in certain basic self-care functions such as bathing, dressing, and eating, and limitations in IADL's refer to levels of disability in the performance of a daily routine, including shopping, cooking, and cleaning. The 1982 survey found that approximately 850,000 elderly individuals were residing in the community with severe limitations in activities of daily living.

Of the 4.6 million disabled elderly, almost 70 percent relied exclusively on nonpaid sources of home and community health care. Almost 1 million received at least some paid care and only 240,000 used paid care only. Of those who received both paid and unpaid care, nearly 41 percent were sole payors for this care, Medicare paid for community care for 8.4 percent of this group and Medicaid paid for about 6 percent. Private insurance pays only about 1 percent of the Nation's long-term care bill.

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[2] Ibid.

3. COVERAGE AND FINANCING

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, inkind transfers, or the provisions of goods and services. Most of the public sector's expenditures for long-term care services, however, are for institutional care—primarily for nursing homes.

In 1985, total expenditures for nursing home care were $35.3 billion. Between 1965 and 1983, the total cost of nursing home care increased 7 percent above the rate of inflation, and is projected to continue rising an average of 4.7 percent above inflation each year between 1983 and 1990. In constant dollars, total nursing home expenditures will increase by more than 50 percent between 1980 and 1990. Forty-seven percent of nursing home expenditures was financed by Federal, State, and local governments.

By far the largest portion of public expenditures for nursing home care is financed by the Medicaid Program for the poor and medically indigent. In 1986, Federal and State Medicaid expenditures for nursing home care amounted to $16.6 billion—representing approximately 42 percent of total national spending, 89 percent of public spending for nursing home care, and 44 percent of total Medicaid spending for all covered health care services.

By way of contrast, the Medicare Program accounts for only a small portion of the Nation's expenditures for nursing home care. Medicare's expenditures amounted to $585 million and represented less than 2 percent of national spending and 3.5 percent of public spending for nursing home care in 1985.[3]

(A) MEDICAID

(1) Coverage

The Medicaid Program, which provides medical assistance for certain low income persons, excludes most older Americans. Medicaid has nonetheless become the primary source of public funds for nursing home care. Approximately 89 percent of all public expenditures for nursing home care is paid by Medicaid and 48 percent of all nursing home residents are Medicaid beneficiaries. Each State administers its own program and, subject to Federal guidelines, determines the Medicaid income eligibility standard.

State Medicaid Programs are required by Federal law to cover the categorically needy, that is, all persons receiving assistance under the Aid to Families with Dependent Children [AFDC] Program and most people receiving assistance under the Supplemental Security Income [SSI] Program. States may also cover persons who would be eligible for cash assistance, except when they are residents in medical institutions, such as skilled nursing facilities [SNF's] or intermediate care facilities [ICF's].

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[3] HCFA, Office of the Actuary.

In addition, States may, at their discretion, cover the medically needy, that is, persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for medical care. These State variations mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

To control costs and to provide a range of community-based services to the Medicaid-eligible population, many States have applied to the Department of Health and Human Services [DHHS] for section 2176 Medicaid waivers. In 1981, congress established these waivers, giving DHHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a SNF or ICF. Services covered under the 2176 waiver include case management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. While this new waiver option has been enthusiastically received by the States, there is concern about the administration's support for the 2176 waiver program, as is discussed later in this chapter.

(2) Expenditures

Federal Medicaid expenditures for nursing home care in 1986 were approximately $17.6 billion, of which $5.5 billion was spent on SNF's, $6.9 billion for ICF's and $5.2 billion for ICF for the mentally retarded.[4] Medicaid financed 89 percent of Federal spending and 43 percent of total nursing home expenditures. Even though the elderly and disabled constitute only 28 percent of Medicaid recipients, they account for 74 percent of Medicaid expenditures. More striking, nursing home residents comprise only 7 percent of all Medicaid recipients, but account for 48 percent of all costs.[5]

Medicaid expenditures have been growing rapidly since 1972, but the fastest growth has been in long-term care (nursing home) expenditures. (See chart 8-5.) Increasing numbers of elderly nursing home residents accounts for a portion of this growth, but the cost of nursing home care has grown at twice the rate of beneficiary growth. For example, the number of ICF residents (non MR) grew by 3.9 percent between fiscal year 1984 and 1985, while the cost per resident grew by 7.7 percent, nearly twice the rate.[6] The growth in costs for SNF benefits is even more dramatic: The number of recipients actually declined by 2.2 percent during this period while costs per resident rose by 7.7 percent.

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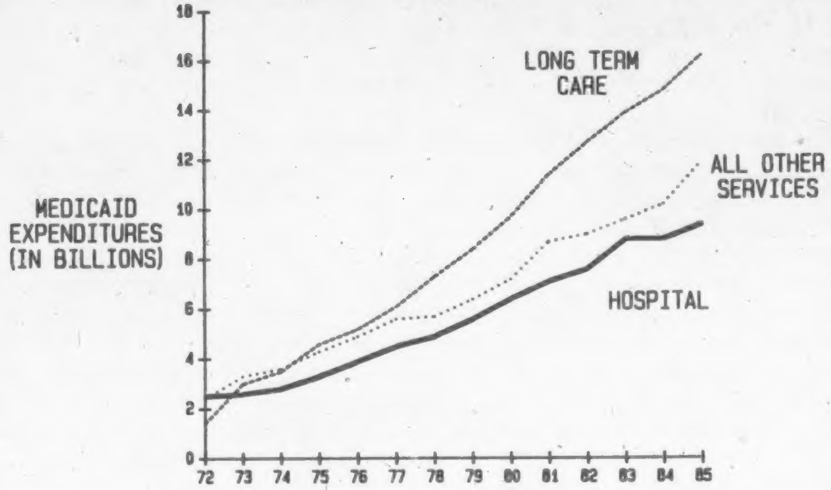
[4] Health Care Financing Administration, unpublished data based on November 1986 data.

[5] Ibid.

[6] Congressional Budget Office, 1987.

CHART 8-5

GROWTH IN MEDICAID EXPENDITURES
1972 - 1985



SOURCE: U.S. Health Care Financing Administration, 2082 Medical Care Statistical Report, December 30, 1986

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1985, Federal Medicaid expenditures for home health care were $1.1 billion, accounting for less than 3 percent of total Medicaid spending. In 1982, the last year in which these data were collected, home health benefits constituted more than 1 percent of total Medicaid expenditures in only nine States. One State, New York, spent 78 percent of all Medicaid home health dollars.[7]

Because Medicaid expenditures consume between 10 to 15 percent of State budgets, many States are seeking to control the growth of their nursing home population and their obligated Medicaid expenditures. As many as 26 States made changes in nursing home reimbursement policies to reduce costs in 1981 and 1982, with several States adopting a preadmission screening process and limits for the number of beds reserved for Medicaid beneficiaries.

(B) MEDICARE

(1) Coverage

The Medicare Program, which insures almost 98 percent of all older Americans without regard to income or assets, does not cover either long term or custodial care. Primarily, it provides acute care coverage for those age 65 and older, particularly hospital and surgical care and accompanying periods of recovery. For example, Medicare covers up to 100 days of SNF services following a hospital stay of at least 3 consecutive days. Further, in order to receive reimbursement under Medicare, the patient must be in need of skilled nursing care on a daily basis for treatment related to a condition for which he or she was hospitalized. The SNF benefit is subject to a daily patient copayment after the 20th day of care. In 1986, the copayment was $61.50 per day, rising to $65 in 1987. The program pays for neither intermediate care facility services nor custodial care in a nursing home.

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[7] Health Care Financing Administration, Medicaid Statistics Branch, 1986.

Even though Medicare coverage of home health care is only for short periods of care and only for treatment of an acute care condition or for post-acute care, the Medicare home health benefit is the fastest growing component of the Medicare Program.

Home health services covered under Medicare include the following:

—part time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;

—physical, occupational, or speech therapy;

—medical social services provided under the direction of a physician;

—medical supplies and equipment (other than drugs and medicines);

—medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and

—part time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must be in need of part time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, e.g., deductibles or coinsurance, for covered home care.

In addition to these SNF and home health care benefits, Medicare covers a range of long-term care services, and especially home care services, for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, therapy services, medical social services, home health aide services, physician services, counseling, and short term inpatient care. For fiscal year 1985, Medicare paid $15 million in benefit payments for hospice care.

There is no statutory limit on the number of home health visits covered under Medicare; but according to HCFA, home health care should generally be available for just a few weeks. HCFA's recent attempts to restrict use of the home health benefit have been the subject of congressional hearings and legislation, discussed in more detail later in this chapter.

While coverage of long-term care services is restrictive and limited, older Americans apparently believe that Medicare's coverage includes basic long-term care services. In fact, a recent survey by the American Association of Retired Persons [AARP] found that of older persons surveyed, fully 79 percent believed that Medicare would pay for part, if not the entire cost, of their nursing home care.

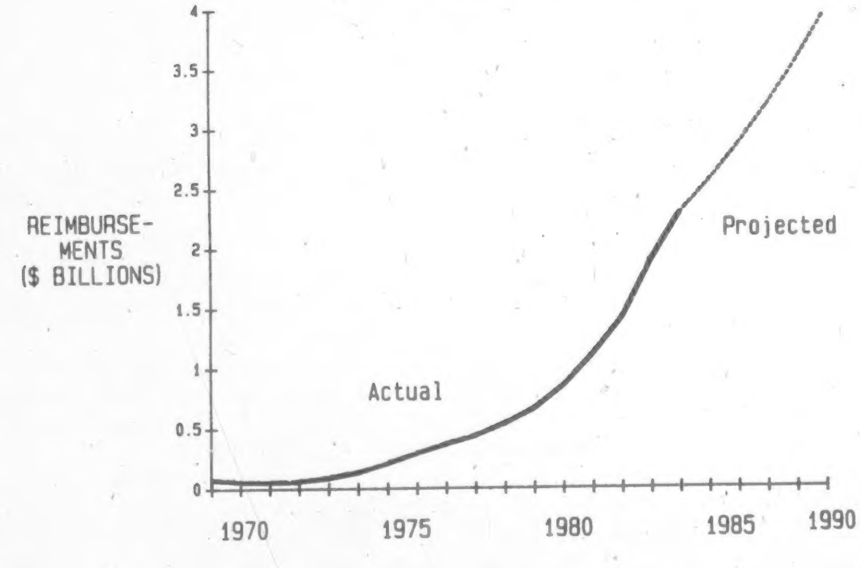
(2) Expenditures

Medicare expenditures for long-term care generally have been small. In 1985, Medicare's contribution to SNF care was only $590 million, less than 2 percent of total public and private spending for nursing home care and less than 1 percent of total Medicare spending.[8]

Medicare payments for home health care comprise less than 3.3 percent of total program outlays. For calendar year 1986, total reimbursements for Medicare home health services were projected to be $2.5 billion. Chart 8-6 indicates, however, that Medicare's home health benefit expenditures are the fastest growing component of the Medicare Program.

CHART 8-6

MEDICARE HOME HEALTH REIMBURSEMENTS
1969 - 1990



SOURCE: HCFA/Bureau of Data Management and Statistics

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[8] O'Sullivan, Jennifer, Medicare: Fiscal year 1987 Budget, Congressional Research Service, Education and Public Welfare Division, August 18, 1986, updated, p. 6.

(C) TITLE XX

(1) Coverage

Title XX of the Social Security Act authorized reimbursement to States for social services, now distributed via the Social Services Block Grant [SSBG]. Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are not appropriate.

Although the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated. Data concerning the extent to which title XX now supports long-term care is therefore unavailable.

(2) Expenditures

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of title XX funds—States are provided relative freedom to spend Federal social service block grant funds on State-identified service needs. Legislation in the 98th Congress permanently increased the per year expenditure ceiling to $2.7 billion, effective in fiscal year 1984. In fiscal years 1985 and 1986 the appropriation level was again $2.7 billion and remains at that level for 1987.

(D) THE OLDER AMERICANS ACT

(1) Coverage

The Older Americans Act [OAA] carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities, and social services. While the OAA thus funds a wide range of supportive services, in-home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each OAA area agency on aging is required to spend a portion of its supportive services allotment on home care services.

The number of home care visits to older persons under the OAA represents only a small fraction of the amount under Medicare and Medicaid. The OAA services, however, are provided without the restrictions called for by Medicare and without the income tests called for by Medicaid. In some cases, OAA funds may be used to service persons whose Medicare and Medicaid benefits have become exhausted or who are ineligible for Medicaid. Approximately 2.4

million in-home service visits were provided under the OAA in 1984.

(2) Expenditures

Unlike the title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of title III funds for supportive services, for congregate nutrition services and for home-delivered nutrition services. States receive allotments of these funds according to the number of older persons in the State as compared to all States. The law gives States and area agencies on aging some flexibility to define the supportive services to be provided and to transfer funds among the three service categories. Total fiscal year 1987 appropriations for title III are $692 million. Fifty percent of the funds, or $348 million, were for congregate nutrition services, and 39 percent, or $270 million, were for supportive services and senior centers. Only about 11 percent of the Federal appropriations, or $74 million, was devoted to home-delivered nutrition services.

(E) PRIVATE INSURANCE

(1) Medigap

Seventy-two percent of older Americans purchase supplemental medical insurance, or medigap policies.[9] About half of this supplemental coverage is provided on a group basis—mainly through retirees' former employers—and about half is purchased individually. These policies are typically designed to supplement Medicare's coverage of acute care costs, not long-term care costs.

To illustrate, some medigap policies cover the daily copayment from the 20th to the 100th day of an approved stay in a Medicare SNF. Others provide coverage for skilled care, as defined by Medicare, in a certified facility for stays of 100 to 356 days, or longer. The value of medigap coverage for long-term care, however, is very limited. These policies generally cover a very small fraction of total nursing home costs and an even smaller portion of home health or custodial care costs.

(2) Long-term Care Insurance Policies

Currently, only about 1 percent of the Nation's long-term care expenditures is paid for by private insurance. A 1986 survey by the Health Insurance Association of America found that 12 companies offered individual indemnity life insurance and that there were 130,000 policyholders with an average age of 75. These policies typically offer indemnity benefits for 3 years of care in a licensed nursing care facility. Ten of the 12 policies continue coverage after the need for skilled nursing care is fulfilled and the long-term care needs become custodial in nature. Fifteen additional companies are developing new products.

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[9] Congressional Budget Office Tabulations of Survey of Income and Program Participation, April 1984 (as cited in Statement of Nancy M. Gordon before the Subcommittee on Health and the Environment, Committee on Energy and Commerce, U.S. House of Representatives, 3/26/86).

There are several common features of the types of benefits offered by these companies. First, they all offer indemnity benefits ranging from $10 to $50 per day. Offering an indemnity benefit, rather than paying the total costs of nursing home services, limits the insurer's liability and thereby reduces the risk of the policy to the insurer.

Second, all policies are offered with either a deductible or a reduced benefit for some initial period of time. Those in the Health Insurance Association of America survey, for example, offered a choice of either 20 or 100 days during which a person must be in a nursing home before payments begin. This ensures that the more frequent short stays do not increase the cost of insuring the less frequent, but more expensive, long stays. In effect, these policies protect against catastrophic costs and are more like casualty insurance than traditional health insurance: Only individuals with extended stays are fully eligible for many plan benefits.

Third, all policies are to some extent oriented to a stay in a SNF or care in a facility with a full-time nurse. By excluding home care benefits, it is easier for the insurer to define the insurable event and thereby, to limit the insurer's liability.

These factors reduce the cost of the policies, but may also reduce both their desirability to many persons and their effectiveness in reducing overall costs. These characteristics of private long-term care insurance may also turn out to be an obstacle to efforts that are underway to stimulate a shift from institutional care to home care.

(F) OUT-OF-POCKET COSTS

While the cost of long-term care represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home and community-based care often falls on individuals and their families.

The vast majority of the chronically ill and disabled elderly population rely exclusively on informal support. Between 70 and 80 percent of those elderly persons living in the community who need long-term care receive all of the care they need from family and friends. The remaining 20 to 30 percent pay for their care themselves, or have some or all of their care paid for by private insurers, Medicare or Medicaid, and family members.[10] Between 60 and 95 percent of home care is given by family and friends.

This home care is rendered to 1.2 million disabled elderly persons by 2.2 million friends and relatives. In 75 percent of the cases, care is given via a live-in arrangement. Ninety percent of the caregivers are low- or middle-income.[11]

Home care is generally a less expensive option for the elderly, but about 14 percent have out-of-pocket costs from home care that range from $360 to $1,680 per year, depending on the level of disability.[12] These out-of-pocket costs are only for home care, they do not include other health-related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

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[10] Callahan et al., 1980; Christianson and Stephens, 1984; Liu et al., 1986; as cited in Stone, Cafferata, Sangl, Caregivers of the Frail Elderly; A National Profile.

[11] (Stone, Cafferata, Sangl, Caregivers of the Frail Elderly: A National Profile.)

[12] 1982 National Long-Term Care Survey.

The cost of community-based care pales in comparison to the cost of nursing home care. The price of a year in a nursing home ranges from $12,000 to $50,000; the cost at even the lower end of this range is beyond the resources of most older Americans. Thus, many elderly people must spend their entire savings and become eligible for Medicaid soon after they enter a nursing home. Currently, between one-quarter and two-thirds of the patients who enter nursing homes as private paying patients subsequently spend down their resources and become eligible for Medicaid. A recent study released by the House Select Committee on Aging shows that this spend down occurs on the average within 13 weeks after admission for the single older American.

B. ISSUES

1. HOME HEALTH CARE DENIALS

In 1983, Medicare changed the method for paying hospitals from a pay-as-you-go system to the prospective payment system [PPS] based on pre-determined rates for specific diagnosis-related groups [DRG's]. Since then, Medicare patients have been sent home from the hospital after shorter stays, in greater need of follow-up health care, than ever before. At the same time, the Health Care Financing Administration, which operates the Medicare Program, has targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit. As a result, more Medicare beneficaries need home health care at a time when less care is available.

A July 28, 1986, public hearing of the Senate Aging Committee, held in Philadelphia, found that increasing numbers of seriously ill Medicare patients are in need of home health care, but that even larger numbers are being denied access to care. Since implementation of the Medicare Prospective Payment System, hospital discharges to home health have increased by 37 percent. During the same period, the rate of growth in home health services has slowed—Medicare-covered visits rose an average of 19 percent from 1980 to 1983, but only 8 percent in 1984, when the demand was greatest.

The committee's investigation found home health care denials have nearly tripled since the first quarter of 1983 when PPS was initiated—during the first quarter of 1985, Medicare denied 47,855 claims. In Pennsylvania alone, 2,332 Medicare beneficaries were denied home health care coverage in the 8-month period between September 1985 and April 1986.

Government policies to restrain beneficiary protections, combined with vague and confusing guidelines for providers, result in reduced access to home health care for older Americans, witnesses told the committee. HCFA uses unwritten and unpublished guidelines to limit the Medicare home health benefit. The Health Care Financing Administration has repeatedly tried to eliminate the "waiver of liability" which gives home health agencies critical flexibility in interpreting Medicare rules and regulations so they aren't forced to deny access in cases where eligibility is in question.

One home health agency, for example, received a denial of home health care benefits for only one patient since the inception of Medicare in 1966—until 25 patients were denied benefits in a recent 6-month period between September 1985 and April 1986.

HCFA has placed limits on home health providers' abilities to appeal decisions denying Medicare beneficiaries home health care and has made it very difficult for Medicare beneficiaries to appeal decisions themselves. HCFA has limited providers' right to appeal denials. For example, technical denials (such as denials based on the definition of homebound) are not paid under the waiver of liability and only a beneficiary can submit a technical denial for reconsideration. Moreover, once a denial is paid under the waiver of liability it cannot be appealed.

HCFA no longer allows Medicare beneficiaries to designate home health providers as their representatives in appealing coverage denials. Many Medicare patients live alone and are too sick to make their way through the bureaucratic jungle to appeal these denials. As a result, Medicare beneficiaries have no realistic protection under the Medicare Program without access to a suitable representative.

At the July hearing, the Aging Committee put forth the following recommendations:

(1) Home health providers should be allowed to represent Medicare beneficiaries in home health appeals.

(2) Fiscal intermediaries should be held accountable in part for incorrect and inappropriate decisions which result in denials of care to Medicare beneficiaries. This can be accomplished by including reversals of fiscal intermediary decisions in performance evaluations for contract renewals.

(3) The waiver of liability should be made a permanent part of the Medicare law and must cover all vague coverage criteria, including that a Medicare beneficiary must be a homebound and must receive only intermittent care.

(4) HCFA should give home health providers clear instructions regarding all rules and regulations affecting the home health benefit and should do everything possible to make the administration of the Medicare home health benefit more consistent and uniform.

(5) HCFA should be brought under the Administrative Procedures Act to ensure public notice of all instructions and transmittals which would have the effect of changing the nature and extent of the Medicare benefit.

(6) HCFA should establish demonstration programs for prior authorization for Medicare home health claims.

(7) Congress should enact S. 778, the Home Care Protection Act, which would ensure beneficiaries adequate home care by clarifying the law to state that the Medicare intermittent home health benefit can include care provided on a daily basis for up to 60 days, with physician certification of need.

A report from the General Accounting Office [GAO], "The Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs," requested by Senator Heinz, was delivered to the committee in December 1986. The blue book report showed that hundreds of thousands of chronically ill older Americans are not receiving the home health assistance they need under the Medicare Program.

GAO attributed much of the problem of inappropriate denials, as well as program abuse, to "vague" coverage criteria. Despite a 1981 recommendation by GAO, the Health Care Financing Administration has not clarified coverage criteria relating to frequency of care, homebound status, or provided enough training on how to interpret existing criteria, the report says. It goes on to say that "inconsistent interpretations of the criteria can result in unequal access to home health services."

The GAO report identifies internal "weaknesses" in administering the home health services and estimates these weaknesses cost the taxpayer almost $600 million in improper payments in fiscal 1984. The report goes on to say that savings realized through improved program controls, such as those recommended in 1981, could be used to provide benefits to those not now served. Recommendations from the GAO include further studies to determine the effect of stronger, clearer guidelines and internal controls over the home health program on the number of Medicare beneficiaries with unmet home care needs.

2. NURSING HOME QUALITY OF CARE

Thousands of old and sick citizens live in nursing homes which fail to provide care adequate to meet even their most basic health and safety needs. The problem of poor quality nursing home care has been exposed and examined many times and in great detail over a period of years, most recently through a 2-year investigation conducted by the Senate Special Committee on Aging. Yet, the remedies always have seemed to be just out of reach.

Unfortunately, many barriers prevent good quality nursing home care from reaching America's oldest and most vulnerable citizens. Federal and State governments, to begin with, have not fulfilled their responsibility to ensure that nursing home residents are provided proper care. While this Nation has come a long way in improving the physical facilities in nursing homes, thousands of patients still suffer from poor nutrition, inadequate nursing care, and general neglect that many people hoped had been corrected long ago by State and Federal reforms.

Existing Federal and State enforcement policies are so seriously lacking that, in 1984, over one-third of the Nation's skilled nursing facilities failed to comply with even the most essential health, safety, and quality standards of care. Nearly 1,000 of these homes failed to meet these basic standards year after year, providing clear evidence that no effective penalties exist to sanction nursing homes that provide poor quality care.

Second, payment for nursing home care, especially under the Medicaid Program, has been inadequate in many areas of the country for years. To some degree, Federal and State governments have been asking for high-quality care at bargain basement prices. Some nursing homes respond to low reimbursements by cutting corners, including hiring untrained or inadequately trained staff.

Today, regulations provide for two types of nursing homes—skilled nursing facilities [SNF's] and intermediate care facilities [ICF's]—and require much less stringent standards for the latter than for the former. In reality, very little difference exists between the types of patients who reside in those facilities. Some have argued that all participating nursing homes should meet a single set of high standards now applied only to SNF's.

At present, the only Federal sanction available is to require that a substandard nursing home be closed and patients moved to other settings. Given the shortage—or absence—of empty beds in most parts of the country, it is understandable why this penalty is rarely used. Legislation introduced by Senators Heinz and Glenn (S. 2604) would mandate surprise, random inspections and create a set of "intermediate" sanctions to be used against nursing homes that violate good quality care standards. These sanctions include civil fines, restrictions on further admission of patients to the facility, and placing substandard facilities under receivership. These intermediate measures would allow patients to continue receiving care while the Federal and State governments monitor required improvements.

To remedy the problem of inadequate payments, this bill proposes the implementation of a case-mix reimbursement system for Medicare and Medicaid nursing homes. Case-mix reimbursement would allow the Federal and State governments to more closely tie patient reimbursement to the level of patient care.

3. Medicaid Coverage for Impoverished Aged

Medicaid was created as the health care safety net for this Nation's poor. On balance, it has served them very well. There are, however, 2.2 million elderly persons whose incomes are a few dollars too high to allow them to qualify for Medicaid under traditional income tests, but far too low to allow them to afford the health care they need. Medicaid currently covers only 36 percent of America's aged poor.

There are only two ways to qualify for Medicaid. Categorical eligibility is linked to eligibility for SSI, while "medically needy" eligibility is determined by spending down through medical costs to 133 percent of the AFDC level. Unfortunately, in both cases the individual's income must be far below poverty. For example, the SSI income eligibility limit is $111 less than poverty ($336) per month for a single person and $199 less than poverty ($504) per month for a couple.

Medicaid coverage for this population group is especially important since the elderly and disabled poor have large health care needs. Death rates among the elderly poor are 50 percent higher than for other Medicare beneficiaries. Despite their greater health needs, they receive 35 percent fewer physician visits, use 29 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital.

4. PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Nearly 800,000 Medicaid nursing home residents depend on their "personal needs allowance" [PNA] each month to cover a wide range of expenses not paid for by Medicaid. The personal needs allowance amounts to $25 a month or 82 cents per day. The PNA has not been increased—even to adjust for inflation—since Congress first authorized payment in 1972. As a result, the PNA is worth less than $10 in 1972 dollars. Thus, all recipients of Social Security and SSI benefits have received COLA's to their benefits since 1974, except the frailest and most vulnerable—Medicaid nursing home residents.

For impoverished nursing home residents, this minimal allotment represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, eye glasses, clothing, laundry, newspapers, and phone calls. In 15 States, more than half of the $25 must be spent on laundry alone.

In addition to personal needs, many nursing home residents have substantial medical needs that are not covered by State Medicaid programs. Although the PNA is not intended to cover medical items, these residents may have to save their PNA's over many months to pay for these costs, preventing them from tending to personal needs.

If a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve his bed there. Even though a resident who cannot pay this fee is likely to lose his place in the nursing home, 40 percent of State Medicaid plans will not cover the cost and guarantee the nursing home resident a bed to come back to.

Concern that the PNA is far too low and below what Congress had originally intended led several Senators to prepare legislation to provide a modest increase in the PNA. The bill, prepared by Senator Heinz and supported by Senators Kennedy, Durenberger, Moynihan, and Glenn, was budget neutral (it actually saved $6 million over 3 years), using savings from a Medicaid second surgical opinion program for certain elective surgeries.

This amendment would not have increased the PNA to a level that would enable nursing home residents to live in luxury, nor would it even have restored all of the purchasing power that the PNA has lost by not being adjusted for inflation in the last 14 years. Rather, this amendment would have increased the PNA by only $5 a month in fiscal year 1988, and allow for a further increase and cost-of-living adjustment beginning in fiscal year 1990.

The second half of the bill—the second surgical opinion program—would provide savings to Medicaid recipients, and State and Federal Governments—not only in terms of dollars, but in human lives as well. Under this provision, Medicaid patients would be required to obtain a second medical opinion before undergoing certain elective surgical procedures, enabling them to protect themselves against unnecessary surgery. The purpose of the second opinion is to inform a patient whether an independent medical evaluation confirms the diagnosis and the necessity of surgery, and to offer for consideration any alternative treatment.

CBO estimated that the second opinion proposal would save the Federal Government $20 million in the first year and $25 million in every year after that. Similar savings will result to State governments.

Congress, in the first session of the 99th Congress, moved to institute a mandatory second surgical opinion program under the Medicare benefit in the Budget Reconciliation Act. In 1986, the administration proposed a Medicaid second opinion program. By including this provision in the 1986 budget reconciliation bill, the Congress could have claimed the savings toward the deficit reduction goal and used part of the savings to increase the meager allotment given to the poorest of the poor—Medicaid nursing home residents.

The costs of increasing the personal needs allowance from its current level of $25 a month to $30 on October 1, 1987, would have been more than offset by the savings available through the Medicaid second surgical opinion program. Pairing these two provisions would result in $20 million fiscal year 1987 savings to the Federal Government and savings to most State Medicaid budgets.

This amendment had the support of the Villers Advocacy Associates, AARP, the Leadership Council on Aging, the Save Our Social Security Coalition, the National Senior Citizens Law Center, the National Council of Senior Citizens, and other key health advocacy groups.

The proposal to increase the personal needs allowance was not offered as an amendment to the reconciliation bill because of time constraints. A version of the mandatory Medicaid second surgical opinion program found its way into law through administrative policy changes.

5. END STAGE RENAL DISEASE

More than half of this Nation's 1,300 end stage renal disease dialysis clinics reuse dialysis devices that are designed and labeled by manufacturers for "single-use only."

Dialysis is a critical life-sustaining treatment required to remove toxins, salt, and water that accumulate in the blood of a person whose kidneys have ceased to function because of end stage renal disease [ESRD]. Treatment requires the patient to be connected three times a week for 3 to 4 hours to a dialysis machine which filters out these life-threatening toxins. The only alternative to dialysis is kidney transplantation. Medicare funds 80 percent of dialysis costs for all ESRD patients.

Life-saving dialysis has been practiced for more than 20 years and today is provided by Medicare at a cost of over $1.5 billion to more than 78,000 patients. More than half (48,000) of the patients are 55 and older; over 26 percent (27,000) are 65 and older; and 34 percent of new patients annually are 65 and older.

A growing practice in dialysis clinics in recent years has been the reuse of certain dialysis devices that are labeled by manufacturers for "single-use only." Reused most often are the plastic cylindrical dialyzer blood filter and the plastic blood lines through which the patient's blood flows to and from the dialyzer. Other equipment subjected to reuse includes the transducer filter and dialyzer caps.

All dialysis clinics are reimbursed by Medicare at the same rate, regardless of whether or not they reuse disposables. Hospital based clinics receive $131 per dialysis treatment, and freestanding facilities are reimbursed $127 per treatment. A new disposable dialyzer costs about $10 and is the most expensive disposable device used in dialysis. Blood lines cost about $3. Reprocessing of these two disposables saves about one-half to one-third the cost of buying new ones each time they are reused. Figures generated by the Office of Technology Assessment indicated that reuse of the dialyzers alone may result in excess profits of $80 million or more each year.

Some dialysis clinicians believe that reuse of the dialyzer combats "first-use syndrome," an allergic reaction to a new dialyzer. The FDA determined that only about 3.3 such reactions per 1,000 patients occurred over a 2-year period. The FDA also found, however, that in most of these cases, the dialysis facility failed to follow the manufacturer's instructions for properly preparing the dialyzer for patient use in order to avoid any negative reaction to the new dialyzer. Clinicians also have found that certain types of membranes used in dialyzers may cause allergic reactions, a problem often solved by switching patients to a dialyzer with a different type of membrane.

More than 60 percent of the dialysis clinics are reprocessing and reusing disposable devices as many as 20 or 30 times by flushing out and "disinfecting" them with a solution most often consisting of formaldehyde and water. Formaldehyde is known to cause cancer, liver damage, and destruction of red blood cells. Research has shown that formaldehyde can cause the formation of antibodies in the blood that may encourage rejection of a kidney transplant. In addition, formaldehyde reportedly causes allergic reactions, and central nervous system and reproductive disorders.

Patients who are treated with reused disposable dialysis devices also face the risk of their devices—and therefore their blood—being contaminated with virulent strains of bacteria if reused equipment is not properly sterilized.

The Senate Aging Committee uncovered these facts through a 4-month, in-depth investigation into the issues of reuse of disposable kidney dialysis devices. During this investigation, interviews were conducted with scientists, clinicians, and patients involved in hemodialysis study, practice, and treatment. Interviews were also conducted with key personnel at the Food and Drug Administration, the Health Care Financing Administration, and the National Institutes of Health. Published research papers were reviewed, as well as thousands of internal records from these three Federal agencies.

On March 6, 1986, the committee held a hearing on reuse of disposable dialysis devices to examine its findings and receive testimony from renal physicians and dialysis patients, as well as from HCFA and the FDA.

Four major problems associated with reusing disposable dialysis devices were brought to light through the investigation and hearing: (1) Proper clinical trials have yet to be conducted to conclusively determine the health effects of reusing disposable devices, (2) the FDA and HCFA have failed to develop standards to ensure safe reuse procedures, (3) dialysis patients who receive dialysis treatment with reused equipment usually are not informed of the potential risks associated with reuse, and (4) dialysis patients who know the potential risks and request not to be treated with recycled equipment are often denied any choice in the matter and are, in effect, forced to submit to treatment with reused equipment.

Many issues were raised in connection with these problems, and many solutions were sought. First was the issue that administration proposed rate reductions would encourage further reuse of dialysis devices. Second, patient advocates wanted ESRD patients to be given the ability to accept or refuse dialysis with reused devices. Third, others wanted no further reuse of dialysis devices or equipment until clinical trials to examine the safety and efficacy, including patient morbidity and mortality, of reuse were conducted.

In 1983, the Health Care Financing Administration moved to reduce reimbursement rates by $12 per treatment in an effort to encourage greater use of home dialysis. Since then, the use of home dialysis decreased and the incidence of reuse—a money-saving procedure for ESRD facilities—skyrocketed from 18 to 60 percent. Those who opposed further rate reductions were concerned that reducing the rates would seriously jeopardize lives and safety of the 80,000 Medicare dialysis patients in this country. For this reason, Senator Heinz pushed the Congress to act in reconciliation conference to keep Medicare ESRD rates at current levels, which would not have the effect of increasing or encouraging reuse.

C. LEGISLATION

1. Home Health

The Omnibus Reconciliation Act of 1986 (Public Law 99–509) included several of the committee's recommendations regarding improvements in home health care. For example, one provision provides beneficiaries with the right to appeal payment denials for home health services that do not meet the "intermittent or home bound" criteria. Also, the waiver of liability for home health agencies was extended and will continue to be in effect until 12 months after the 10 new regional fiscal intermediaries begin operation—a date which is not yet known. Cost limits for home health agencies will be applied on an aggregate basis for all home health services, rather than on a discipline-specific basis, effective with cost-reporting periods beginning on or after July 1, 1986. These latter two provisions are designed to grant home health agencies greater flexibility so they can better serve the Medicare population.

2. Nursing Home Quality Reforms

On June 26, 1986, Senators Heinz and Glenn introduced major legislation that would comprehensively address the many quality of care problems plaguing nursing homes in this country. This legislation, S. 2604, the Nursing Home Quality Reform Act, was based on the findings of the committee's hearing and investigation into the current status of quality of care in nursing homes and on recommendations made by the Institute of Medicine on improving nursing home quality of care.

The purpose of this bill was to first, improve the quality of care and quality of life in nursing homes; and second, to create a strong, effective enforcement system to ensure that substandard care is met with appropriate and swift penalties.

Major portions of the Heinz/Glenn nursing home reform package were included in H.R. 1868, the "Medicare and Medicaid Patient and Program Protection Act," which gained approval of the Senate Finance Committee, but did not see floor action in the 99th Congress. Specifically, the provisions included in the larger bill would:

—Require training and competency testing for nursing home nurse aides.

—Extend the rights of residents in skilled facilities to those in intermediate care facilities.

—Strengthen the enforcement sanctions against homes that discriminate against Medicaid patients.

—Require nursing homes to maintain clinical records on all residents and provide accurate physical assessments for each.

—Require that inspections be unannounced and conducted on a random time schedule.

—Make quality of care the focus of inspection and require public disclosure of all inspection reports.

—Require States to train nursing home inspectors and make each inspection team multidisciplinary.

—Require the Secretary of Health and Human Services to develop a proposal for case mix reimbursement for nursing homes by January 1, 1988.

This issue traditionally evokes strong emotional responses from the various interested parties. From the senior advocates point of view, nursing home residents have long suffered abuse of every sort at the hands of nursing home operators and nursing homes are little more than forgotten warehouses of the old and the infirmed. To the nursing home industry, Medicare and especially Medicaid payments for nursing home residents are far below the actual cost of care and nursing homes are providing the best quality care possible at those bargain basement prices. This issue is sure to be considered in the 100th Congress and has the support and interest of Congressmen Dingell and Waxman, the chairs of the House Energy and Commerce Committee and Subcommittee on Health and the Environment, respectively.

3. MEDICAID COVERAGE FOR AGED POOR

While the 99th Congress was very concerned with cutting programs and reducing the deficit, it still found a way to mend some of the holes in the Medicaid safety net. To address the problem of the aged who fall below the poverty line but do not qualify for Medicaid, S. 2492, the Low-Income Elderly Protection Amendment of 1986, was introduced in the Senate by Senators Heinz, Bradley, and Burdick. A companion bill, H.R. 4882, was introduced in the House by Representatives Waxman and Schumer. Both bills would separate Medicaid eligibility from eligibility for AFDC and SSI, giving the States the option to provide Medicaid coverage—with matching Federal payments—if a senior citizen or a disabled person's income is at or below the Federal poverty rate.

The effect of the bill would be to provide Medicaid health care and prescription drug coverage to low income elderly and the disabled, and to cover their Medicare premiums, deductibles, and coinsurance payments.

The costs of providing this health care coverage to this targeted group was relatively low. The Congressional Budget Office estimated that this legislation would cost the Federal Government only $38 million in the first year and only $79 million per year when fully implemented. This legislation goes hand in hand with legislation introduced earlier in the 99th Congress by Senators Chiles and Durenberger. The Chiles and Durenberger bills would allow States to provide Medicaid coverage to pregnant women and children below the Federal poverty line. S. 2492 complements these bills by giving each State the option of providing Medicaid coverage to elderly and disabled poor only if coverage is also provided to pregnant women and children below the poverty line in that State.

Both initiatives, to expand Medicaid coverage for low-income seniors and for pregnant women and children, were approved as part of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509).

4. Reuse of Kidney Dialysis Equipment

Congress this year also took action to protect patients who have end stage renal disease and are treated with reused dialysis devices that are meant to be used only once. The Senate reconciliation package, as put forth by the Senate Finance Committee, would have cut ESRD reimbursement rates by $1 per treatment, compared with a $5.50 per treatment reduction advocated by the House. The two Houses of Congress compromised through reconciliation conference to reach a $2 per treatment reduction in ESRD facility Medicare payment rates.

To address a second issue of patient choice, Senator Heinz introduced the ESRD Patient Rights Act of 1986. This bill was supported by Senator Glenn. This legislation was to provide dialysis patients with information on the potential risks and benefits of reuse, give patients the right to choose or reject dialysis treatment with recycled dialysis equipment, and ensure that patients cannot be turned away from treatment if they decide not to accept treatment with recycled equipment.

This bill would have resulted in no additional costs to either the Federal Government or dialysis providers. Neither would this legislation add a new and burdensome paperwork requirement to the ESRD program. Currently, facilities are required to receive the patient's written consent before administering treatment in the ESRD program. These written consent forms are kept on file and reviewed by the appropriate State survey agencies in determining whether facilities meet the conditions of Medicare participation. Unfortunately, this legislation was not accepted by the Senate.

To address the third problem of clinical trials, the Omnibus Budget Reconciliation Act (Public Law 99-509) requires that the Secretary impose standards and conditions for safe and effective dialyzer reuse and reprocessing, enforceable as a condition of Medicare participation effective October 1, 1987. Beginning January 1, 1988, no reuse of blood lines, transducers, caps, and other accessories shall be allowed in Medicare-certified ESRD facilities until and unless standards and conditions for safe reuse and reprocessing of these devices and equipment are imposed as a condition of participation.

D. PROGNOSIS

Congress this year may well deal with the problem of uninsured long-term care catastrophic illnesses. While any such action will most likely focus on private efforts, or private/public combinations, for financing coverage expansion, any steps toward providing older Americans and others with ways to pay for nursing home care other than today's reliance on spend down will be welcome. Congress also will almost certainly take up the issue of nursing home quality of care reform to provide solutions to the persistent problems of substandard nursing home care.

Congress also will take up the issues of nursing home prospective payment, nursing home case mix reimbursement, home health care payment and coverage, and welfare reform.

The administration is likely to propose legislation to dramatically restructure the way Medicaid health benefits are provided through the States, by offering States financial incentives to use risk and cost sharing arrangements in the form of health maintenance organizations. Some will probably be receptive to the idea, given the savings that may be available, but the issues of access to health care and the quality of care provided should be given serious consideration. The House may be less enthusiastic about this proposal, however, especially since Congressman Waxman has traditionally been very skeptical of the fairness and quality of care that HMO's and HIO's have to offer Medicaid populations.

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EXECUTIVE SUMMARY

The projected growth of the elderly population, combined with large and increasing public and private out-of-pocket expenditures for long-term care services, and especially nursing home services, has generated substantial interest in altering the way in which long-term care services are financed and delivered. In the past, legislative interest has focused in part on coordination of existing Federal programs financing long-term care in order to offer more consistent and adequate protection for the potentially catastrophic expenditures the elderly can incur as the result of chronic illness. In addition, policy-makers have also sought ways to expand community-based services to correct what some perceive to be a bias in the current system in financing institutional long-term care. This report provides an overview of selected policy issues on long-term care financing, including information on characteristics of the elderly and their need for and utilization of long-term care services, and a review of public sector programs and private sector approaches to financing long-term care services.

The phrase "long-term care" refers to a wide array of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self-care due to chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of individuals needing long-term care include the elderly and non-elderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill. This report focuses principally on long-term care services required by the elderly, generally those persons 65 years and older. Elderly persons, by virtue of their high risk of chronic illness that results in disability and functional impairment, are the primary users of long-term care in this country.

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These conditions may include heart disease, strokes, arthritis, and vision and hearing impariments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly. At least half and perhaps as many as 70 percent of patients with dementia have Alzheimer's disease, a chronic, progressive, primary neurologic degeneration of unknown cause, which increases in prevalence with advancing age and for which there is currently no effective treatment.

Long-term care services include a wide variety of health and social services provided in an institution, in the community, or in the home. Services range from medical and therapeutic services for the treatment and management of chronic illness provided by skilled personnel to assistance with basic activities of daily living, such as housekeeping and personal care services, provided by family members, nurses, and social workers. By far, the majority of long-term care services are provided by family members. Studies have estimated that between 60 and 80 percent of the care received by the impaired elderly is provided by relatives and friends who are not compensated for the care they provide.

Based on the projected growth of the elderly population and current utilization patterns of institutional and community long-term care services, major increases in the demand for long-term care can be anticipated for the future. Today approximately 1.4 million elderly persons are residents of nursing homes. This is about five percent of the total elderly population. With current utilization, the National Center for Health Statistics has estimated that the number of elderly nursing home residents will increase by 58 percent from 1978 to 2003 when constant mortality is assumed and by over 115 percent when declining mortality is assumed. In addition, for every person 65 years of age and over residing in a nursing home, there are twice as many persons living in the community requiring the various kinds of care provided in an institution.

Expenditures for long-term services, and especially for nursing home care, strain the budgets of public programs, as well as private resources. In 1985, total national nursing home expenditures of $35.2 billion were financed about equally by public programs and private sources of payment. Public programs financed $16.5 billion of the total, and private sources $18.7 billion. Of total private spending for nursing home care in 1985, less than 2 percent was paid by private insurance coverage. Ninety-seven percent of the total private spending for nursing home care was paid directly by the consumer out-of-pocket. The average annual cost of nursing home care is in the range of $20,000 to $25,000 per year, representing a catastrophic expenditure beyond the financial reach of most elderly.

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or the provision of goods and services. Among these 80 programs, five are generally considered to be the major programs of Federal support for long-term care and these are discussed in detail in this report: Medicaid, Medicare, the Social Services Block Grant, the Older Americans Act, and the Supplemental Security Income program. It should be noted that there are a host of other Federal programs providing services such as specialized housing and transportation services to the functionally disabled elderly. In addition, numerous long-term care benefits are offered to veterans through the Veterans Administration. No one program, however, has been designed to support a full range of long-term care services on a systematic basis.

The Medicare program is intended to address the acute medical care needs of the aged and disabled. To the extent that it provides coverage for certain long-term care services, it does so with the intent of reducing the need for more intensive and expensive acute care services. The program was not designed to respond specifically to the chronic care needs of the elderly, for instance those with Alzheimer's disease, over a sustained period of time.

The Medicaid program on the other hand, does support long-term services, principally nursing home care, but only for certain low-income people or for persons who have depleted their income and assets. The Medicaid program financed 42 percent, or $14.7 billion, of the Nation's total expenditures for nursing home care in 1985. This total also represented nearly 90 percent of public spending for nursing home care.

Observers have noted that Medicaid's eligibility policies and benefit structure have actually created financial incentives to use nursing homes rather than community services. In general, Medicaid support to the chronically impaired elderly living in the community has usually been quite limited. In addition, certain elderly poor who are ineligible for Medicaid while living in the community may become eligible once they enter a nursing home, because the State has a higher income eligibility standard for nursing home residents.

Others become eligible for Medicaid once they deplete their resources after entering the nursing home as privately paying patients. A 1983 GAO report reviewed studies showing that one-quarter to two-thirds of Medicaid patients in nursing homes initially entered as private paying patients and subsequently converted to Medicaid.

While the Medicaid program is the predominant Federal program supporting long-term care services, two Federal social service programs provide community-based services which may prevent or delay institutionalization--the Social Services Block Grant program and the Older Americans Act. However, their total resources are small in comparison with total Medicaid expenditures devoted to both institutional and community-based long-term care services. The Social Services Block Grant program is generally limited to the provision of social services selected and defined by the State, and provides services not only to the elderly, but also to families and children. Funding under title III of the Older Americans Act is used for the development of a service delivery system for older persons, focusing on social and nutritional services.

In addition to these programs, the Supplemental Security Income (SSI) program provides cash assistance to needy aged, blind, disabled individuals, but can include, at the discretion of the States, supplemental payments to support selected community-based long-term care services.

While these various Federal programs supporting long-term care provide a measure of flexibility to target services on specific groups or needs, their differing eligibility requirements, service benefits, service definitions, and reimbursement policies have resulted in a fragmented and uncoordinated long-term care policy at the Federal level. In addition, this lack of coordination among Federal programs has also presented major implementation challenges to the States, especially where certain of these programs delegate administrative responsibility to State governments.

The following chart summarizes some of the major differences among Federal programs which support institutional and community-based care.

Major Federal Programs Supporting Long-Term Care Services: Services Covered, Eligibility, and Administering Agency

			Administering agency	
Program	Services covered	Eligibility	Federal	State
Medicaid/ Title XIX of The Social Security Act	Skilled nursing facility a/ Intermediate care facility b/ Home health c/ Adult day care b/ Personal care b/	Aged, blind, disabled persons receiving cash assistance under SSI; others receiving cash assistance under AFDC. At State option, persons whose income exceeds standards for cash assistance under SSI/AFDC, i.e., the "medically needy."	Health Care Financing Administration/ HHS	State Medicaid agency
	2176 "waiver" services, e.g., case management, homemaker, personal care, adult day care, habilitation, respite, and other services at State option. d/	Aged, blind, disabled, or mentally ill Medicaid eligibles (including children) living in the community who would require nursing home level care. At State option, persons living in the community with higher income than normally allowed under a State Medicaid plan.		In some cases, the 2176 "waiver" program may be administered by another agency, e.g., State agency on aging.
Medicare/ Title XVIII of the Social Security Act	100 days of skilled nursing facility care Home health Hospice	Generally Social Security status. Persons 65 years and over; persons under 65 years entitled to Federal disability benefits; and certain persons with end-stage renal disease.	Health Care Financing Administration/ HHS	N/A

**Major Federal Programs Supporting Long-Term Care Services:
Services Covered, Eligibility, and Administering Agency--Continued**

			Administering agency	
Program	Services covered	Eligibility	Federal	State
Social Services Block Grant/Title XX of the Social Security Act	Various social services as defined by the State, including homemaker, home health aide, personal care, home-delivered meals	No Federal requirements. States may require means tests.	Office of Human Development Services/HHS	State social services/human resources agency. In some cases other State agencies may administer a portion of title XIX funds for certain groups, e.g., State agency on aging
Older Americans Act/ Title III	Variety of social services as determined by State and area agencies on aging, with priority on in-home services. Also case management, day care, protective services. Separate appropriation for home-delivered meals.	Persons 60 years and over. No means tests, but services are to be targeted on those with social or economic need.	Administration on Aging/Office of Human Development Services/ HHS	State agency on aging

Major Federal Programs Supporting Long-Term Care Services: Services Covered, Eligibility, and Administering Agency--Continued

			Administering agency	
Program	Services covered	Eligibility	Federal	State
Supplemental Security Income/ Title XVI of the Social Security Act	Federal income support. Maximum Federal payment for persons with no income is $340 per individual and $510 per couple in 1987. Supplemental payment for non-medical housing and/or in-home services, at State option.	Aged, blind, disabled persons who meet Federally established income and resources requirements. States may make payments to other State-defined eligibility groups.	Social Security Administration/ HHS	State supplemental payment program may be State or Federally administered.

a/ Required for individuals over age 21.

b/ At option of State.

c/ Required for individuals entitled to skilled nuring home care.

d/ May be offered under a waiver of Medicaid State plan requirements, if requested by the State and approved by HHS. May include waiver of Medicaid eligibility requirements and stipulation that services be offered on a statewide basis.

Policymakers have also been concerned about striking the right balance between nursing home care services and home and community-based long-term care services. By far the largest portion of public expenditures for long-term care is for nursing home care, with the Medicaid program accounting for 42 percent of total national spending for nursing home care. Other programs, such as the Social Services Block Grant and the Older Americans Act, while providing a range of community-based long term care services, have limited ability to provide a balance to the enormous institutional support provided through the Medicaid program. Long-term care reform in the past, therefore, has included efforts to reduce inappropriate institutionalization of the chronically ill by creating programs to assure that those referred for institutional care actually need such care and by increasing the availability of community-based care services, such as home care and adult day care services.

Various Federal research and demonstration projects have attempted to test new ways of providing and coordinating long-term care services. Some of these projects have led to the National Long-Term Channeling Demonstration program by the Department of Health and Human Services (DHHS). With nursing home care representing a substantial portion of public and private expenditures for long-term care, these research and demonstration efforts have had the following objectives: (1) to reduce the cost of long-term care by reducing inappropriate institutionalization and the demand for institutional care by persons who could otherwise be served through community-based services at less cost; (2) to test whether a carefully managed system of care would create more efficient use of existing services and deter unnecessary institutionalization; and (3) to make available to clients a wider range of community-based services than previously existed. At best, the demonstrations have had mixed results in terms of overall costs savings, reductions in the use of institutional care, and effects on client functioning. Based on the weight of evidence emerging from the enormous amount of research which has been conducted on the effects of community-based care, many analysts have come to the conclusion that the promotion of such care as a cost-effective alternative to institutional care was based on a faulty premise. Analysts and service providers alike have increasingly recognized that expanded community care services may in fact represent new services that result in additional expenditures for a functionally impaired population which is not at imminent risk of institutionalization but which nevertheless needs help to remain at home.

Another major research and demonstration initiative of DHHS currently underway is the social/health maintenance organization (S/HMO). This project builds upon and extends the health maintenance organization model, where health care services are offered to a defined population on a pre-paid capitation basis. The S/HMO provides not only conventional health care services to a group of elderly persons but also provides a range of long-term care services including nursing home care, home health, and homemaker services. Among the questions to be addressed by this demonstration are whether a consolidated pre-paid system of acute and long-term care can produce greater savings than conventional HMOs already serving Medicare beneficiaries, and whether the long-term care services offered through the program will reduce nursing home admissions and the number of persons who become eligible for Medicaid's nursing home benefit after they have depleted their income and assets on expenditures for long-term care.

Uncertainty about the potential costs of expanded community-based care, and intervening concern about budget deficits and increasing expenditures under entitlement programs which currently finance long-term care, have shifted the focus of the long-term care debate from reform of Federal programs to consideration of private sector initiatives which might relieve fiscal pressures on public programs. In addition, these private sector alternatives are believed to offer potential protection against the private catastrophic expenses that can result from a need for long-term care. Some of the private sector options advanced as feasible alternatives for financing long-term care include private health insurance, life care communities, and home equity conversion. Not discussed in this report are other options often suggested as alternative financing mechanisms for long-term care, including the various tax code amendments proposed to assist families to continue providing long-term care services.

Currently, relatively few insurance companies (studies indicate 12 to 38) write long-term care insurance policies which are substantially more comprehensive than standard policies supplementing Medicare coverage. It is estimated that these policies cover from 50,000 to 150,000 persons. A number of barriers have been cited as impediments to the development of meaningful long-term care insurance policies, such as the potential for adverse selection (where only persons more likely to need long-term care buy insurance) and induced demand (where individuals decide to use more services because they have insurance and/or will shift from non-paid providers, such as family members, to paid providers of care). Recent research, however, suggests that some of these barriers may be resolved in a number of ways, including expanding the pool of the insured by encouraging people to buy at younger ages.

Life care communities, also called continuing care retirement communities, are living arrangements available to a limited but potentially growing number of older persons. Such communities are established to provide housing, meals, housekeeping, and certain long-term care services, as necessary, to older persons for the duration of their lives. Older persons enter into a contractual agreement which sets forth the services to be received by the resident in exchange for financial payments, including an entrance fee and monthly payments. The number of existing life care communities is estimated to range from 300 to 600, but this number is expected to more than double in this decade. Supporters of this concept indicate that a life care contract provides financial protection against the future costs of long-term care and offers a protective living arrangement for persons whose needs will increase over time. However, because of the substantial fees required for entrance, some analysts believe this option may be available to only a limited proportion of the elderly population.

Home equity conversion contracts, in which older persons use the equity in their homes to finance certain expenses, have also been advanced as a means to finance certain long-term care services. While substantial numbers of elderly persons have accumulated equity in their homes, to date only a very limited number (estimates of about 300-400 at most) of home equity conversion contracts have been negotiated.

Observers have pointed out that the economic status of future generations of the elderly may improve to the extent that they will be able to finance, through risk pooling arrangements, at least a portion of their long-term care expenses themselves, without resorting to the impoverishment currently required under Medicaid to qualify for that program's nursing home benefit. In addition, others have noted that public programs will simply not be able to support expanded long-term care services in the future as the ratio of workers to retirees declines and as the number of the very oldest segment of the population increases. For the time being, however, these options appear to provide only limited opportunities for alternative financing schemes for long-term care. In addition, they seem to have only limited applicability for the large numbers of elderly who are poor or may be poor in the future.

Reproduced from Statement of Nancy M. Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office, before the Health Task Force, Committee on the Budget, U.S. House of Representatives, October 1, 1987. [Washington, Congressional Budget Office, 1987] p. 14-17. [This statement also appears in U.S. Congress. House. Committee on the Budget. Task Force on Health. Budget issues related to long-term health coverage. Hearing, 100th Congress, 1st session. Oct. 1, 1987. Washington, G.P.O., 1987. p. 174-177.]

IMPLICATIONS FOR THE FEDERAL BUDGET

To illustrate the impact of the three different approaches to financing future long-term care, two possible options are specified under each approach. [7] Table 2 briefly describes these options and their impacts on total spending for long-term care and on the federal budget.

Under the first approach, two options would make only incremental changes in current public programs: one would combine federal funding for long-term care into block grants to states; the other would modify Medicaid's eligibility rules to allow spouses of institutionalized people to retain more of the couples' incomes or assets. As for the second approach in which the government facilitates private-sector solutions, one example is a federal "stop-loss" program that would pay for long-term care after a person's spending or length of stay in an institution had passed certain high thresholds. Another example is an income-related voucher or refundable tax credit that would provide a partial subsidy for individuals who purchase private long-term care insurance. The third approach is illustrated by a federal mandate of employment-based insurance coverage and by a fully public long-term care insurance program. The Appendix provides more detail about each of these examples.

If any new strategy for long-term care financing becomes law in the future, numerous decisions must be made about eligibility, types of

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7. Consideration of more than a few of all the spending and tax treatment options that have been suggested for changing long-term care financing is beyond the scope of this short statement.

TABLE 2. ILLUSTRATIVE OPTIONS FOR LONG-TERM CARE (LTC): ESTIMATED IMPACTS AS IF FULLY IMPLEMENTED IN 1985

Illustrative Option a/	Target Population	Changes in Primary Financing Sources b/		Percentage Increase in Spending for LTC Services Over Current Law c/	
		Public	Private	Total	Federal
Modify Current Programs:					
- Comprehensive block grants to the states to replace current federal financing of LTC.	People with state-defined low incomes.	Any lower administrative costs used to "fund" additional services.	None.	0-1	0
- Income or asset protection for "community" spouses of institutionalized people. d/	Spouses of institutionalized people.	Higher outlays by federal and state Medicaid programs.	Less paid out-of-pocket.	0-1	1-3
Encourage Private Solutions:					
- Federal "stop-loss" program to pay for LTC after a high spending or length-of-stay threshold was passed. d/	Entire population.	Larger federal outlays for "stop-loss" and smaller federal and state outlays for Medicaid.	Less paid out-of-pocket; more paid through individual LTC insurance premiums.	5-15	20-45
- Income-related voucher or refundable tax credit for purchasing LTC insurance. d/	People age 45 and older.	Higher federal outlays or reduced federal revenues for subsidies.	Less paid out-of-pocket; more paid through individual LTC insurance premiums.	5-25	20-40
Assure Universal Coverage:					
- Federally mandated employment-based LTC insurance coverage. d/	Workers (active and retired) and spouses.	Lower federal and state outlays for Medicaid.	Less paid out-of-pocket; more paid through employer-employee LTC insurance premiums.	25-45	0-10
- Public LTC insurance program.	Entire population.	Larger federal outlays.	Much less paid out-of-pocket.	30-50	150-275

SOURCE: Congressional Budget Office.

a. See the Appendix for more detailed descriptions of these options.

b. The financing aspects are compared with current law and policies. Under current law, most public funding for LTC comes from the Medicaid program that involves both federal and state revenues; private sources are 97 percent out-of-pocket financing.

c. The estimates apply to spending in a single year (1985), assuming that the options had been fully implemented by then. In some cases, the impact on the federal budget would occur through lower tax revenues, rather than higher spending. Both outcomes would raise the federal budgetary deficit unless offsetting actions were also taken.

d. The Medicaid program would continue for people meeting its income and asset criteria who were not otherwise covered.

long-term care services to be covered, financing sources, reimbursement methods, mechanisms for assuring high quality care, and the locus of administration. This brief testimony does not address the trade-offs involved in designing a particular policy, even though each illustration had to be specific in order to estimate the amount of spending that would be involved and the impact on the federal budget.

Table 2 shows that, if these options had been fully implemented in 1985, total spending on long-term care would have remained essentially the same as under current law or increased by as much as 50 percent. The amount of increase depends mainly on whether individuals would make voluntary decisions about purchasing long-term care insurance or whether participation would be mandatory. As a final caution, bear in mind that, because total expenditures are expected to rise substantially in future decades under current law, many of these approaches would considerably expand spending for formal services.

In contrast, the impact on the federal budget would be determined mainly by the extent to which the federal government assumed responsibility for long-term care and the extent to which that responsibility was met directly, instead of requiring others to fund it. Federal outlays would be affected least by options that would require others to pay for long-term care. For example, despite their similar impacts on the total spending for long-term care, mandating employment-based insurance coverage would not increase federal spending, although federal tax revenues might be lower. In contrast, a fully public long-term care system might increase federal outlays by as much as 275 percent.

CONCLUSION

The need for long-term care services will require a growing share of society's resources in the coming decades. Demographic trends alone will almost certainly bring about this need, and it will be exacerbated if the price of medical care and the intensity of services increase at past rates. In addressing problems with the current system for financing long-term care, two major decisions must be made. First, the total amount of national resources to use in providing long-term care must be determined. Second, the division between private and public means of financing and controlling the long-term care system must be resolved.

Reproduced from The risk of long term care induced impoverishment; Chapter III. In Long term care and personal impoverishment: seven in ten elderly living alone are at risk; a report presented by the Chairman of the Select Committee on Aging, House of Representatives, 100th Congress, 1st session, Oct. 1987. p. 5-17. (Comm. Pub. No. 100-631)
[This chapter also appears in U.S. Congress. House. Select Committee on Aging. Long term care and personal impoverishment: seven in ten elderly living alone at risk. Hearing, 100th Congress, 1st session. Nov. 9, 1987. Washington, G.P.O., 1988. p. 34-45.

CHAPTER III:

The Risk of Long Term Care Induced Impoverishment

In examining the risks related to long term care, consideration must be given to two major factors -- your risk of needing long term care and your financial risk when you use long term care. As stated in a recent study by the Department of Health and Human Services, elderly persons aged 65-69 years face about a 5 percent risk of entering a nursing home in the next five years and **face a 43 percent risk of entering a nursing home during their remaining lifetime.** Nearly 7 million people need long term care currently. By the year 2040, this number is projected to triple to 19 million people. (Department of Health and Human Services Task Force on Long-Term Health Care Policies, 1987)

To document the level of long term care related financial risk faced by the elderly, the Select Committee on Aging staff, with the assistance of the Villers Foundation, the Urban Institute and Dr. Laurence Branch (Boston University), developed a model for estimating financial risk. (See Appendix A.) This model and the resulting study focus on America's elderly as the population most vulnerable because of both long term care need and limited incomes. However, many of the same observations and many of the results related to personal risk apply as well to America's non-elderly. Estimates of long term care induced risk are made for 1) the proportion of the elderly at risk of impoverishment based on the number of weeks in a nursing home or receiving home care and 2) the personal risk of impoverishment based upon that individual's income and financial assets.

Proportion of Elderly at Risk of Impoverishment — National Findings.

After only **13 weeks** in a nursing home, **7 in 10 elderly persons living alone find their income spent down to the federal poverty level.** Within one year of entering a nursing home, over **90 percent** of these elderly are impoverished. Even when both income and financial assets are considered, nearly one-half (48 percent) of the elderly living alone are impoverished after only 13 weeks in a nursing home. Within one year, two-thirds of elderly living alone use up **both** their income and financial assets and could face a second year of long term care with their life savings depleted and a limited income. (See Chart 1 and Table 1.)

While the picture for married couples is somewhat less tragic -- they either have more income and financial assets or are facing long term care costs for the first time -- the impact of long term care costs is still staggering for them. Looking at income only, **over one-half of the couples are impoverished after one spouse has spent only one-half year in a nursing home.** Even when both income and financial assets are taken into account, nearly one-half of the couples are impoverished after one year in a nursing home. (See Chart 2 and Table 1.) This latter situation means that elderly couples face the second year with no financial assets and face the same rate of impoverishment as when income only is considered. **Not only are couples at great risk, but the at-home spouses, usually the wife, face their own health and long term care needs with no financial assets and with only limited income.**

Though home care is often a viable and preferred alternative to nursing home care, the risk of impoverishment remains great when extensive home care is needed. The Committee staff analysis looks at two different situations, home care provided 7 days per week and home care provided 5 days per week.

CHART 1

PERCENTAGE OF OLDER SINGLE PERSONS
AT RISK OF IMPOVERISHMENT,
BY WEEKS OF NURSING HOME CARE

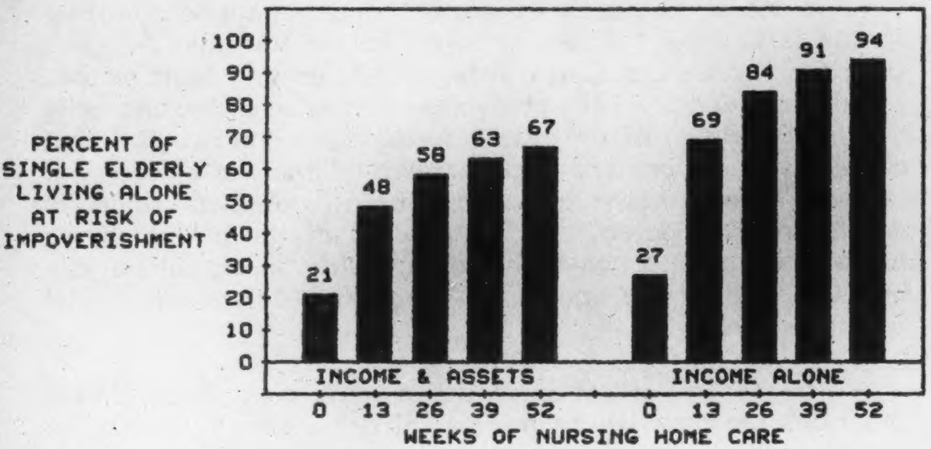
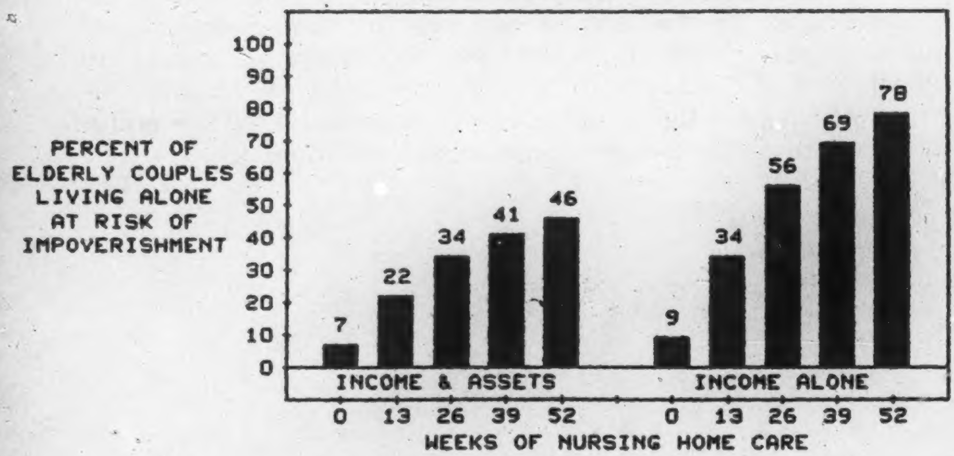


CHART 2

PERCENTAGE OF OLDER COUPLES LIVING ALONE
AT RISK OF IMPOVERISHMENT,
BY WEEKS OF NURSING HOME CARE



SOURCE: Select Committee on Aging
U.S. House of Representatives
October, 1987.

The first situation, 7-day-a-week care, would generally be home care for a person needing extensive supportive services. For example, it may be either an elderly person is living alone or an elderly couple is living alone where neither spouse is sufficiently able to be an active caregiver. In this case, home care costs, at a rate of $43 per day, could exceed $15,000 per year. As the study shows, looking at income only, nearly **90 percent of the elderly living alone and two-thirds of couples living alone are impoverished by the end of one year of 7-day-a-week home care.** When both income and financial assets are considered, over 60 percent of the elderly living alone and about two-fifths of couples living alone are impoverished by the end of one year of 7-day-a-week home care. (See Table 2.)

The second situation, 5-day-a-week care, more likely describes the case where there is either a working spouse or caregiver or where there is a caregiver, possibly a spouse, who may not be completely healthy and may be able to provide only limited assistance. In this case, home care costs could easily exceed $11,000 per year. As the study shows, looking at income only, over **80 percent** of the elderly living alone and over **one-half** of couples living alone are impoverished by the end of one year of even 5-day-a-week home care. When both income and financial assets are considered, 57 percent of the elderly living alone and one-third of couples living alone are impoverished by the end of one year of 5-day-a-week home care. (See Table 3.)

TABLE I. PERCENTAGE OF OLDER PERSONS AT RISK OF IMPOVERISHMENT BY WEEKS OF NURSING HOME CARE

Based on Income Only

	NUMBER OF WEEKS OF CARE				
NATIONWIDE	0	13	26	39	52
	SINGLES ALONE (%)				
65+	27	69	84	91	94
75+	29	73	86	92	95
	COUPLES ALONE (%)				
65+	9	34	56	69	78
75+	13	43	66	77	83

Based on Combined Income and Financial Assets

	NUMBER OF WEEKS OF CARE				
NATIONWIDE	0	13	26	39	52
	SINGLES ALONE (%)				
65+	21	48	58	63	67
75+	22	50	59	65	68
	COUPLES ALONE (%)				
65+	7	22	34	41	46
75+	9	28	40	45	51

SOURCES: House Select Committee on Aging (1987); The Urban Institute's TRIM2 Model based on March 1984 Current Population Survey (1987); Health Care Financing Administration (1987).

TABLE 2. PERCENTAGE OF OLDER PERSONS AT RISK OF IMPOVERISHMENT BY WEEKS OF EXTENDED HOME CARE

7 Days A Week

Based on Income Only

NATIONWIDE	NUMBER OF WEEKS OF CARE				
	0	13	26	39	52
	SINGLES ALONE (%)				
65+	27	61	75	84	89
75+	29	66	80	86	90
	COUPLES ALONE (%)				
65+	9	25	43	56	67
75+	13	33	53	67	74

Based on Combined Income and Financial Assets

NATIONWIDE	NUMBER OF WEEKS OF CARE				
	0	13	26	39	52
	SINGLES ALONE (%)				
65+	21	43	52	58	62
75+	22	46	54	60	64
	COUPLES ALONE (%)				
65+	7	16	28	34	39
75+	9	21	34	40	44

SOURCES: House Select Committee on Aging (1987); The Urban Institute's TRIM2 Model based on March 1984 Current Population Survey (1987); Health Care Financing Administration (1987).

TABLE 3. PERCENTAGE OF OLDER PERSONS AT RISK OF IMPOVERISHMENT BY WEEKS OF EXTENDED HOME CARE

5 Days A Week

Based on Income Only

	NUMBER OF WEEKS OF CARE				
NATIONWIDE	0	13	26	39	52
	SINGLES ALONE (%)				
65+	27	55	68	77	83
75+	29	60	73	81	85
	COUPLES ALONE (%)				
65+	9	19	34	45	54
75+	13	26	44	56	64

Based on Combined Income and Financial Assets

	NUMBER OF WEEKS OF CARE				
NATIONWIDE	0	13	26	39	52
	SINGLES ALONE (%)				
65+	21	40	48	53	57
75+	22	42	50	55	59
	COUPLES ALONE (%)				
65+	7	13	22	29	33
75+	9	17	27	35	39

SOURCES: House Select Committee on Aging (1987); The Urban Institute's TRIM2 Model based on March 1984 Current Population Survey (1987); Health Care Financing Administration (1987).

Proportion of Elderly at Risk of Impoverishment — State Findings.

While this study of long term care induced financial risk focuses on national data, the Current Population Survey sample was large enough to provide **first-time** insights into how the elderly fare in some of the larger States. The detailed tables for nursing home care and both 7-day-a-week and 5-day-a-week home care are in Appendix B. Different States have different percentages of impoverishment for a particular group of elderly due to differing income and financial asset levels as compared to differing costs of nursing home care. Due to the lack of detailed data on home care costs, national average home care costs are used for all States. As a result, different rates of impoverishment among States for home care primarily result from differences in elderly income and financial assets.

As can be seen from the detailed state tables in Appendix B, the larger States differ substantially with respect to rates of impoverishment. Focusing primarily on nursing home care and looking at income only, the percentage of elderly couples impoverished after 13 weeks in a nursing home ranges from a low of 15 percent to **a high of 59 percent.** For the elderly living alone, the risk is much higher **-- from a low of 56 percent to a high of 79 percent at risk of impoverishment.**

When both income and financial assets are included, the percentage of elderly living alone who are impoverished after 13 weeks in a nursing home range from a low of 29 percent to a high of 62 percent. Similarly, for couples living alone, the percentages who are impoverished range from a low of 9 percent to a high of 43 percent.

While "13 weeks in a nursing home" is one critical time period for analysis, a second critical time period is "one year in a nursing home." As elderly persons or elderly couples suffer through a full year in a nursing home and with both their income and financial assets being used up, the prospects for a second year in a nursing home are especially devastating. At the end of one year in a nursing home, using both the income and financial assets of couples living alone, the percentage of impoverishment in the larger States ranges from a low of 28 percent to a high of **69 percent.** For the elderly living alone the situation is substantially worse. The percentage of long term care induced impoverishment ranges from a low of 56 percent to a high of 82 percent -- **over 8 in 10 elderly living alone.**

Individual Risk of Impoverishment by Income Level.

The perilous state of the elderly population as a whole may seem somewhat abstract and distant from the day-to-day realities. However, another part of the analysis looks at personal risk based upon income. If you are over the age of 65, are living alone, and have an annual income between $9,700 and $15,000 (between 200 and 300 percent of the poverty level), you would be impoverished after only 17 **weeks,** on average, in a nursing home. **However, if your annual income is between $6,000 and $10,000 (between 125 and 200 percent of the poverty level), it would take only 6 weeks, on average, in a nursing home before you would be impoverished.** Even if you have the average amount of financial assets for this latter income group, your income and your financial assets would last only 32 weeks, on average, after you enter a nursing home. (See Table 4.)

Even for couples, the risk of personal impoverishment is great. Again focusing on nursing home care, couples living alone with annual incomes of less than $13,000 are impoverished after one spouse spends only 10 weeks in a nursing home. Even when both income and financial assets are included, couples with annual incomes between $8,000 and $13,000 are impoverished within 27 weeks, on average, of entering a nursing home. (See Table 4.)

Though several examples have been detailed above, the primary value of the following tables is to examine your own situation or that of your parents or grandparents. You can take your income (or your income and financial assets) and see how long your financial resources would last. If you have parents and grandparents, you can do the same for them. With this sense of the personal risk associated with your family's particular personal circumstances, you can better appreciate why elderly Americans, as well as non-elderly Americans, greatly fear not only a long term illness, such as Alzheimer's disease, but the tremendous personal financial risk that is associated with a long term illness.

TABLE 4. AVERAGE WEEKS TO POVERTY WITH NURSING HOME CARE

INCOME ONLY
ANNUAL INCOME (% OF POVERTY)

	100-125%	125-200%	200-300%
Singles	$4860-6075	$6075-9720	$9720-15,000
Couples	$6540-8175	$8175-13,000	$13-20,000
		SINGLES ALONE (Weeks)	
65+	1	6	17
75+	1	6	17
		COUPLES ALONE (Weeks)	
65+	2	10	23
75+	2	10	23

INCOME AND FINANCIAL ASSETS
COMBINED ANNUAL INCOME AND ASSETS (% OF POVERTY)

	(100-125%)	(125-200%)	(200-300%)
Singles	$4860-6075	$6075-9720	$9720-15,000
Couples	$6540-8175	$8175-13,000	$13-20,000
		SINGLES ALONE (Weeks)	
65+	8	32	97
75+	9	36	110
		COUPLES ALONE (Weeks)	
65+	18	27	94
75+	21	32	108

SOURCES: House Select Committee on Aging (1987); The Urban Institute's TRIM2 Model based on March 1984 Current Population Survey (1987); Health Care Financing Administration (1987).

TABLE 5. AVERAGE WEEKS TO POVERTY WITH EXTENDED HOME CARE — FIVE DAYS PER WEEK

INCOME ONLY
ANNUAL INCOME (% OF POVERTY)

	(100-125%)	(125-200%)	(200-300%)
Singles	$4860-6075	$6075-9720	$9720-15,000
Couples	$6540-8175	$8176-13,000	$13-20,000

	SINGLES ALONE (Weeks)		
65+	3	13	34
75+	3	12	33

	COUPLES ALONE (Weeks)		
65+	4	19	46
75+	4	19	45

INCOME AND FINANCIAL ASSETS
COMBINED ANNUAL INCOME AND ASSETS
(% OF POVERTY)

	(100-125%)	(125-200%)	(200-300%)
Singles	$4860-6075	$6075-9720	$9720-15,000
Couples	$6540-8175	$8175-13,000	$13-20,000

	SINGLES ALONE (Weeks)		
65+	16	65	193
75+	17	73	221

	COUPLES ALONE (Weeks)		
65+	34	53	187
75+	38	62	215

SOURCES: House Select Committee on Aging (1987); The Urban Institute's TRIM2 Model based on March 1984 Current Population Survey (1987); Health Care Financing Administration (1987).

TABLE 6. AVERAGE WEEKS TO POVERTY WITH EXTENDED HOME CARE — SEVEN DAYS PER WEEK

INCOME ONLY
ANNUAL INCOME (% OF POVERTY)

	(100-125%)	(125-200%)	(200-300%)
Singles	$4860-6075	$6075-9720	$9720-15,000
Couples	$6540-8175	$8175-13,000	$13-20,000
	SINGLES ALONE (Weeks)		
65+	2	9	24
75+	2	9	24
	COUPLES ALONE (Weeks)		
65+	3	14	33
75+	3	14	32

INCOME AND FINANCIAL ASSETS
COMBINED ANNUAL INCOME AND ASSETS (% OF POVERTY)

	(100-125%)	(125-200%)	(200-300%)
Singles	$4860-6075	$6075-9720	$9720-15,000
Couples	$6540-8175	$8175-13,000	$13-20,000
	SINGLES ALONE (Weeks)		
65+	12	46	138
75+	12	52	158
	COUPLES ALONE (Weeks)		
65+	24	38	133
75+	27	45	154

SOURCES: House Select Committee on Aging (1987); The Urban Institute's TRIM2 Model based on March 1984 Current Population Survey (1987); Health Care Financing Administration (1987).

Reproduced from Medicaid eligibility for the elderly in need of long term care, by Edward Neuschler and Claire Gill. Washington, Congressional Research Service, 1987. p. 1-2, 66-76. (CRS Report no. 87-986 EPW)

INTRODUCTION

A. Medicaid and Long Term Care: The Importance of the Issue

Enacted in 1965 and implemented by the several states between January 1966 and January 1970, Medicaid is the principal public program financing health care services for the poor. Together, states, counties and the federal government expect to spend about $50 billion in fiscal 1987 to pay for services and to administer the program, although fewer than 40 percent of persons with incomes below the federal poverty line are covered by the program (1985). Of the 3,456,000 non-institutionalized elderly living in poverty in 1985 [Census, 1986a], only about 32 percent were covered by Medicaid. [Census, 1987]*

Medicaid is often perceived as the health care program for welfare mothers and their children and, in fact, over 70 percent of Medicaid recipients are children and their caretaker parents. But Medicaid has also become something that was not foreseen when it was enacted—the principal public program financing long term nursing home care for the elderly and disabled. In calendar 1986, Medicaid paid 41.4 percent of the total national nursing home bill. Medicare paid 1.6 percent, private health insurance 0.8 percent and other private funds 0.7 percent. Direct patient payments accounted for 51.0 percent of the total $38.1 billion bill. (The remaining 4.5 percent came from government payments other than Medicare and Medicaid.) [HCFA, 1987]

Viewed from another perspective, in fiscal 1985, almost 31 percent of Medicaid expenditures went to pay for care of the elderly and disabled in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs)—the two levels of nursing home care paid for by Medicaid. Another 12.6 percent was spent on facility-based care for the mentally retarded and developmentally disabled. When home health and personal care services (3 percent) and inpatient mental health care (3.2 percent) are included, almost 50 percent (49.7 percent) of Medicaid expenditures in fiscal 1985 was spent on long term care services. And this large figure does not include other Medicaid expenditures on behalf of long term care patients, such as physicians' services and prescription drugs.

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* The percent of the poor elderly covered by Medicaid was calculated by the author from a Census report on receipt of noncash benefits [Census, 1987] which gives a slightly lower estimate of the total number of elderly living in poverty—3,369,000—than the basic Census report on poverty status [Census, 1986a]. The discrepancy is apparently due to nuances of household composition and whose income is being counted.

In the long term care context, Medicaid serves more than just the chronically poor. Given the short-term, rehabilitative focus of Medicare's skilled nursing home benefit and the lack until very recently of private insurance products providing coverage for long term nursing care, the crippling expense of long term nursing home care exhausts the life savings of many formerly middle class elderly and forces them to apply for Medicaid coverage for their nursing home stay.

F. Summary and Conclusions

Medicaid is the primary public program providing coverage of long term care services for the elderly. It also provides significant coverage of acute health care needs not covered by Medicare—primarily prescription drugs**—for the poorest among the elderly population living in the community. Major issues about the basic design of Medicaid that have been debated for many years include whether Medicaid eligibility and service coverage rules encourage nursing home care even when long term care at home would be cheaper and more appropriate, and whether the program allows individuals living at home to retain sufficient income to meet their non-medical maintenance needs. More recently, there has been specific concern about the latter issue as it relates to the spouses of Medicaid nursing home patients.

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* No lien may be imposed against the recipient's home if any of the following currently and lawfully live there: a spouse, dependent children, or a sibling of the applicant, if the sibling is a co-owner and has resided in the home for at least one year prior to the applicant's admission to a nursing home. Any lien imposed is automatically dissolved if the recipient is discharged from the nursing home and returns to the home.

** Medicare coverage of prescription drugs may become available in the future—subject to a substantial deductible—if currently pending legislation is enacted.

Although motivated by these major, long-standing policy issues, this report was not intended to analyze them fully. Rather, its intent is to provide necessary background information about what Medicaid eligibility policies are actually in place in the several states at this time, and to give the reader a general sense of how those policies operate and how they affect elderly individuals and their spouses who are seeking Medicaid assistance, particularly for long term care services. A full understanding of how current policy operates is necessary before alternatives can be rationally debated. To this end, this concluding section will also suggest areas for additional research, particularly as regards the actual impact of current policies, to further inform the policy debate.

Medicaid eligibility policies affecting the elderly may be summarized as follows:

1. For Individuals Without Spouses or Dependents

In order to receive Medicaid payment for nursing home care, an elderly individual without a living spouse must:

- have very limited—virtually no—assets other than a home,
- not have given away significant assets within the previous 24 months,
- be unable to afford to pay the nursing home charge from current income,
- find a nursing home willing to admit him or her, and
- be medically in need of the level of care provided in a skilled nursing facility or intermediate care facility.

Meeting the resource (asset) is the most important financial criteria when nursing home care is sought. Certain assets such as household goods and personal effects of moderate value, income-producing property, burial spaces and funds, and small amounts of life insurance are excluded from consideration; but other assets must not exceed $1,800 for a single individual in most states. (Six states use slightly lower levels; nine use higher. The range is $1,000 to $4,000.) In 31 states, the nursing home patient's former home continues to be excluded as a resource indefinitely, at least if the recipient states that he intends to return to the home; the remaining states either limit the exclusion to a specified number of months or require a physician's certification that the patient is likely to return home, or both.

Because of the resource limitations, elderly individuals who have accumulated assets during their working lives have two options. Either they must foresee the potential need for Medicaid coverage well in advance and begin giving away their assets to their desired heirs. (Such transfers made within two years prior to applying for Medicaid will result in a period of ineligibility in most states.) Or they must spend virtually their entire life savings, except perhaps the equity in their homes, on their maintenance and medical needs before they apply for Medicaid.

In contrast, current income is not as important an eligibility consideration for the elderly in nursing homes. In 30 states, all elderly who meet the resources test and who cannot afford to pay nursing home charges out of current monthly income are eligible for Medicaid. In the remaining states, all but relatively high income elderly (generally, over $1,020 per month; the lowest state is $632) are eligible.

Once they are eligible, however, nursing home residents must pay virtually all of their current income toward the nursing home bill, with Medicaid paying the difference between the Medicaid rate for the facility and the "patient-pay" amount. Depending on the state, residents may keep $25 to $70 per month for personal needs and, in 29 states, may keep some income to pay for the maintenance of their former home, if a physician certifies that they are likely to return home within 6 months. (Protection of income for a spouse at home is discussed later.)

Of course, before Medicaid can pay for an elderly individual's nursing home care, there must be a bed available for him. Of 42 reporting states, 32 had average statewide nursing home occupancy rates of 90 percent or higher. Twenty-eight states reported that at least some patients had difficulty finding a bed. Heavy care needs seemed to be the most important factor when nursing home placement was difficult.

Finally, patients seeking Medicaid payment of nursing home care must be medically in need of such care. Medicaid programs are required to evaluate each applicant's need for admission, but 30 states have gone further and have instituted formal preadmission screening programs. These programs determine the need for and appropriateness of nursing home placement based on an assessment that goes beyond financial eligibility criteria and a physician's review to include an on-site assessment of the patient's need by a disinterested third party. Many states use such assessments to identify people who could be cared for in their own homes or in the community at lower cost if appropriate services can be made available.

Alternatives to nursing home care for the elderly are, as was mentioned, a major policy issue. Generally, Medicaid cannot pay for non-medical care—such as cooking, cleaning or chore services—needed in addition to home health care to support frail elders in their own homes. But a special waiver program for home- and community-based services, enacted in 1981, now allows states to pay for such non-medical services for persons who would otherwise need to be in a nursing home. As of July 1987, 37 states are using waivers to serve about 59,000 elderly clients. (Some programs only operate in part of a state.)

A major issue in providing home-based services as an alternative to nursing home care is whether the recipient has sufficient income to pay for maintenance needs not covered by Medicaid—food, rent, utilities, etc. Like nursing home patients, recipients of waiver services must also pay part of the costs of the care they receive (unless they receive cash assistance). The amounts states permit single recipients to retain for maintenance needs range from $233 to $1,020 per month (50.8 to 222.5 percent of poverty). Fourteen states permit the standard SSI amount of $340 per month (74.2 percent of poverty), 4 allow less than that, and 19 permit higher amounts. In eight states, the protected amount exceeds the 1987 federal poverty level for an individual ($458.33 per month).

2. For Individuals With Spouses

When the individual in need of long term nursing home care has a spouse, the issues become somewhat more complicated. Before the advent of the federal SSI program in 1974, state Medicaid programs generally considered spouses to be financially responsible for one another, even when one of them was in a nursing home. SSI considers each spouse's income and assets to be available to the other spouse only when the two actually live together. Almost all states now follow SSI rules for Medicaid eligibility purposes. Thus, when determining Medicaid eligibility for a nursing home resident who has an outside spouse:

- Resources owned solely by the outside spouse are not counted, regardless of amount, except in four states.
- The home remains exempt from consideration as long as the outside spouse lives there. (One state puts a dollar limit on the value of the home.)
- In most states, bank accounts held jointly are considered fully available to the applicant, but withdrawals by the outside spouse are permitted without penalty. In others, the accounts are divided proportionally among the owners, and withdrawal by a non-applicant of more than his/her share is considered a potentially disqualifying transfer of assets.
- Other jointly held assets are considered to be divided between the applicant and the outside spouse, but might not be considered an "available" resource if the spouse refuses to liquidate them. (State policies on this issue could not be definitively determined.)
- The outside spouse is not forced to contribute toward the cost of the applicant's nursing home care, no matter how much income he or she has, except in three states. (One of these imposes the requirement only for six months.) Ten other states expect the outside spouse to contribute but cannot enforce the requirement except through court action, which is rarely taken; and one takes action only in exceptional cases.

When the Medicaid-eligible nursing home resident has current income and the outside spouse has little or none, federal rules require states to permit the institutionalized spouse to set aside some income (i.e., not have to pay it to the nursing home) for the needs of the outside spouse. Amounts so protected range across states from as little as $150 per month to as much as $632. The protected amount is less than the basic SSI payment of $340 per month (74.2 percent of the 1987 poverty level) in 17 states; it is higher in 20 states. Only 5 states protect an amount equal to 99% of the federal poverty level or more. Eight states will protect additional amounts if so ordered by a court.

Because the outside spouse's income and resources are generally not counted, it makes a great deal of difference to the couple—and particularly to the financial condition of the outside spouse—who owns the assets and who has the income. Generally, states follow SSI on this point, using the "name on the instrument" rule to determine what belongs to whom. But two of the nine "community property" states have fought in court for the right to use their community property rules in determining ownership of income and resources for Medicaid purposes. In those two states, at least half of community assets and at least half of community income are protected for the outside spouse before the rules noted above are applied.

A few other states have sought to protect resources for the outside spouse by specifically permitting the nursing home applicant to transfer assets to the outside spouse. Amounts permitted vary widely among these states.

Providing long term care at home is probably easier when the applicant in need has a spouse who can help with much of the care, but Medicaid eligibility standards for persons living in the community are difficult for many such couples to meet. Therefore, most states providing alternative long term care services under a waiver have chosen to determine eligibility in these cases under the more liberal rules that apply to nursing home applicants. About two-thirds do not consider the income or resources of the non-applicant spouse when determining Medicaid eligibility for long term care at home. Amounts protected for the maintenance needs of the couple range from $233 to $1,375.

3. "Spend-down" In the Community

This report focused primarily on Medicaid eligibility for nursing home and other long term care services, with only brief attention to the eligibility rules employed for elders living in the community who need Medicaid help for acute health care services, such as prescription drugs. But to round out the discussion it may be noted that, in 37 states, elders whose resources are within allowable levels but whose income exceeds the standard used for automatic Medicaid eligibility may still become eligible for Medicaid if they have incurred sufficient out-of-pocket medical expenses. The difference between their income and the eligibility standard is computed and, once their incurred medical bills exceed this amount, they become eligible for Medicaid.

This process, called "spend-down" and described in more detail in Part II (see Table C-4), is administratively complex and cumbersome; it requires significant ongoing communication between the applicant and the eligibility worker. Applicants must accumulate bills and return them to the eligibility worker when the specified amount is reached. Workers must check the bills, certify the applicant as eligible and complete the forms necessary to issue a Medicaid card. Since eligibility will often be attained in the middle of a month, a special Medicaid card will probably have to be issued manually. States must also have systems to assure that bills used to meet the recipient's liability are not subsequently submitted to and paid by Medicaid. Because of the administrative complexity, the current "spend-down" system works more easily for individuals who have a single large bill, perhaps from a hospital stay, than for individuals who have many small expenses—physicians' visits and prescriptions—on an ongoing basis.

4. Estate Recovery and Liens

The Medicaid statute permits states to recover from an individual's estate costs the state incurred in providing medical assistance to that individual after he or she reached age 65. About half—23—of the states have provisions authorizing them to make such recoveries, but not all use the authority. A few states—particularly Oregon—have well-developed systems that recover significant amounts, certainly well in excess of the administrative resources invested. Only three states, however, have chosen to implement the 1982 authority allowing them to place a lien against the former home of a nursing home recipient as a means of simplifying the recovery process.

5. Issues For Future Research

This report has only been able to describe the policies states have in place to determine Medicaid eligibility of the elderly. It has not been able to assess how many of the elderly are affected in what ways by the Medicaid eligibility system, or to analyze the potential impact of alternative approaches. Additional research is needed to answer such questions as:

a. Conversion From Private Pay To Medicaid: How many elderly initially enter a nursing home as private pay and become eligible for Medicaid after exhausting their resources? How much income do they have and how large are their resources when they enter the home?

Some limited research based on state Medicaid computer files is beginning to be done on the numbers of persons who initially enter as private pay and how long it takes them to become eligible, but to our knowledge there is no research as yet on their financial and socio-demographic status at the point of nursing home entry. Some relevant information may be available from the 1985 National Nursing Home Survey, which is just becoming available.

b. "Estate Planning": To what extent are individuals transferring assets, to heirs or trusts, more than two years in advance of Medicaid application, in order to assure Medicaid eligibility while protecting assets?

Hard figures are virtually non-existent, but a substantial body of anecdotal evidence suggests that growing numbers of elders are being counseled to consider the potential need for Medicaid coverage of nursing home care when arranging their financial affairs. A number of national magazines have run articles on the subject, and lawyers and financial planners in many cities across the country advertise the need to plan for this eventuality. Possible mechanisms include early transfer or gift of assets and establishment of various kinds of trust arrangements. Current law only permits states to consider transfers of assets occurring within the two-year period prior to application for Medicaid, thus precluding denial of Medicaid eligibility for earlier transfers, regardless of the amount transferred. Better information on the extent of this activity is clearly needed, to determine whether policy changes are required.

c. Home- and Community-Based Care: What has been the impact of the Medicaid home- and community-based services waiver program? Do recipients have sufficient income and resources to be able to meet all their needs—including basic maintenance—and maintain themselves at home?

The impact of this major new waiver program is obviously of significant interest to policymakers at many levels. A number of evaluations are underway and should be reviewed closely to determine whether all the significant issues have been addressed. The impact of income and resource issues should not be overlooked.

d. Eligibility Barriers to Home-Based Care: How many elderly in need of home-based long term care cannot obtain it because they do not meet Medicaid eligibility criteria but cannot afford to pay out-of-pocket for the care? Would a program based on a sliding fee scale, rather than an all-or-nothing means test, serve these people better, and at what cost?

When the potential still exists to maintain a person less expensively in his or her own home or in a community setting, there are strong incentives, both public and private, to do so. Current Medicaid eligibility rules may create a barrier to receipt of needed services that could prevent institutionalization. Amounts of income protected for maintenance needs may be insufficient to support a household whose monthly expenses are relatively fixed and are probably in excess of welfare levels; and allowable resources, in particular, may be so low that elders are reluctant to continue to live at home with such a small reserve for major contingencies. Thus, an examination of alternatives to the current, essentially all-or-nothing Medicaid rules may be appropriate for this type of situation. Alternatives might include sliding-scale fees and changing the resource criteria from an all-or-nothing threshold to a percentage contribution requirement. Information needed to estimate the cost of such a program—available income and resources of elders, the extent of their chronic care needs, and how those needs are currently met—may be available from a 1982/84 survey of the non-institutionalized disabled and from state analyses of how long it takes private pay nursing home patients to use up their assets and qualify for Medicaid. Currently available information needs to be synthesized and a determination made as to what additional information is needed.

e. Private Long Term Care Insurance: Will broader availability of private long term care insurance help to reduce Medicaid long term care outlays in future years? Are modifications of Medicaid eligibility policy needed to encourage purchase of such insurance or to make it more affordable for lower income individuals?

There has been considerable interest recently in the potential use of private long term care insurance to help solve the problem of increasing public expenditures for long term care. Several major reports on this topic are in preparation elsewhere and should be released shortly. However, preliminary results from some of these studies suggest that, unless a way can be found to reduce premiums significantly, the impact of private insurance on Medicaid expenditures will be minimal. Those who can afford to purchase private long term care insurance generally have sufficient income and resources that they do not now become Medicaid eligible in large numbers, even if they need nursing home care.

These preliminary results have led some analysts to suggest integrating Medicaid and long term care insurance in some way, perhaps by extending public coverage of nursing home care (whether under Medicaid or a new program) without a resources test to anyone who has paid privately (out-of-pocket or through insurance) for a specified period of nursing home care—24 months is often suggested. Premiums for private insurance for a two-year nursing home stay would be significantly lower and, it is argued, more low- and moderate income individuals could thus afford private coverage. The research question is whether Medicaid savings for some patients during the first two years of nursing home care would be more or less than new public costs for patients staying more than two years, many of whom are not now covered by Medicaid. The answer is by no means obvious, and additional analysis is clearly needed. Several states are hoping to establish demonstration programs to test proposals of this sort.

f. "Spend-down" in the Community: How well does the current "spend-down" system meet the needs of elderly persons living in the community? Would a premium or "buy-in" system meet their needs more effectively? At what cost?

As noted above, the current "spend-down" system is quite complex, and apparently does not serve very well individuals who have many small medical expenses rather than one large bill. A system that permitted individuals to purchase Medicaid coverage by paying a premium, perhaps equal to their "spend-down" liability, perhaps determined under an alternative sliding scale, would be administratively simpler and might better assure access to care. It would, however, probably increase Medicaid outlays in most cases. No major study of the "spend-down" process for applicants residing in the community, how it works and who it covers, has been done since about 1975. Analyses of the 1980 National Medical Care Utilization and Expenditure Survey, currently underway, may provide some information about persons with incomes above Medicaid eligibility levels who have had some medical expenses paid for by Medicaid and about persons who might have qualified under "spend-down" had they applied. These analyses should provide some useful information, but additional data collection may be needed.

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Part III
Chapter 12: Choices for Change

Proposals for changing the way health care resources are allocated in this country are described in the following charts. These ideas represent a synthesis of opinions gleaned from interviewing interested key leaders and completing an extensive literature search. Eric Oxfeld of the U.S. Chamber of Commerce advises that proposals for reforming the financing and delivery of health care for the aged need to be realistic and representative of broad thinking if they are to become workable solutions.

Evaluating each proposal in terms of appropriateness (whose responsibility?), potential for addressing the real problems, and general impact on the American economy, the health care industry and its employees, government at all levels, all taxpayers, and the aged American population is important.

The following options are listed in the accompanying charts, with accompanying pros and cons.

1. Means-test all government health care benefit programs, including Medicare and VA medical benefits.
2. Develop a single comprehensive national acute health care program, with emphasis on health promotion, and block grant long term care funds to the states.
3. Establish health bank account individual retirement accounts called individual medical accounts (IMA'S).
4. Establish a voluntary voucher system for use in all government benefit programs, particularly Medicare and Medicaid.
5. Require financial participation by adult children, especially in long term care.
6. Establish the national lottery to finance health care for the aged (and disabled).
7. Encourage the development of Preferred Provider Organizations (PPO's).
8. Advance the age of eligibility for government benefit programs, indexing to life expectancy.
9. Levy or increase federal excise taxes on alcohol or tobacco earmarking the revenues to support health care of the aged.
10. Encourage states to adopt all-payers systems to control health care costs.
11. Tax employer-provided health insurance exceeding certain limits and earmark for health care of the aged.
12. Encourage all states to enact "natural death laws" with provisions for advance directives and living wills to forego life-sustaining procedures when death is imminent.
13. Expand prevention-oriented and prescreening medical benefits to facilitate healthier lifestyles and early detection and treatment for diseases.
14. Encourage the development of prepaid capitated plans such as Health Maintenance Organization (HMO's) and Social/Health Maintenance Organizations (S/HMO's).

Medicare only:

15. Reallocate the tax rates between the Hospital Insurance Trust Fund and the Old Age Survivors Insurance and Disability Trust Fund to take advantage of the surpluses accumulating in the latter fund.
16. Discontinue or limit funding medical education through Medicare.
17. Encourage Home Equity Conversion and reverse mortages.
18. Eliminate a separate carrier/intermediary for railroad retirees under Medicare.

Option 1. Means-test all government health care benefits programs including Medicare and VA medical benefits.

Pro's

- Would reduce present as well as anticipated government spending on health care for older Americans (current proposal in 99th Congress would reduce Medicare spending $5.4 billion over three years).
- Can be accomplished through a variety of approaches such as universal eligibility with income-related premiums; income-related cost sharing provisions for out-of-pocket expenses or means-tested eligibility to enroll.

Con's

- Drastically curbs accessibility to health care for aged beneficiaries.
- Opens the door to erosion of benefits over the long term.
- Shifts responsibility to the elderly to obtain costly private coverage and/or provide for their own personal health care needs.
- Could result in withdrawal from program if too expensive for higher income aged who may seek cheaper alternatives.
- Could cost more to administer than would be saved in the long-run.
- May not reduce federal outlays significantly as anticipated as a majority of the older population is in the low to middle income category.
- Does not address the basic issue of containing health care costs.

Option 2. Develop a single comprehensive national acute health care program with emphasis on health promotion, and block grant long term care appropriations to the states.

Pro's

- Allows states the flexibility to develop long term care plans based on local need and constraints.
- Permits the federal government to establish uniform eligibility standards and benefits for the low income now served under Medicaid.
- Provides for some public financing of LTC developed in tandem with private sector financing.
- Protects those most in need of protection.
- Consolidates administration and management, thereby reducing costs.

Con's

- Could conceivably increase costs to government.

Option 3. Establish health bank account IMA's.

Pro's

- Enables and encourages individuals to plan and provide for their own future health care needs.
- Phases in over an extended period, possibly 30 years.
- Reduces the anxiety the aged have about the possibility of being confronted with medical expenditures beyond their means to pay for them.
- Provides tax incentives for working Americans.
- Accrues to the aged person's estate on his or her death.
- Represents long term restructuring of the financing of health care for older Americans.
- Costs workers less over the long run.
- Allows for a wider scope for the operation of private market incentives as individuals would use their IMA income to purchase insurance and services from the private market (increases competition among health care providers).
- Lessens the financial pressures on government to fund health care.
- Provides financial incentives to consumers to conserve medical resources.
- Encourages consumers to maintain healthy lifestyles and thereby minimize the costs of health care.
- Encourages private savings which will boost the economy.
- Sharply increases workers' control and choice over individual medical coverage.
- Frees government resources to provide essential aid such as catastrophic coverage.
- Reduces the anticipated growth of government medical spending over the long run.
- Totally replaces the current Medicare system, representing broad reform of how health care of the aged is financed and delivered.
- Reduces payroll taxation for employers, employees, and the self employed.
- Requires no reduction in existing health care benefits and has the potential to produce additional benfits at reduced costs.
- Protects future medical security of today's young worker through the establishment of an improved and soundly based system.

Con's

- Creates a two-class health care system.
- Discriminates against the poor who may be financially unable to establish an IMA.
- Represents no immediate savings to government health care insurance programs.
- Could cause a reduction of federal tax revenues, possibly even adding to the national deficit.

Option 3. Continued

Pro's	**Con's**
• Provides market return to capital workers' contributions. (No such return is available under the current system).	
• Expands the role of the private sector by enabling most workers to place funds in IMA's which would then be invested in private industry.	
• Should even be within the financial means of minimum wage workers to establish IMA's.	
• Protects the poor with means-tested supplements.	
• Would boost national savings.	

Option 4. Establish a voluntary voucher system.

Pro's	**Con's**
• Brings competitive forces to bear on the private marketplace, thereby controlling health care costs.	• Could result in adverse selection with aged individuals who have high health care needs remaining in the traditional program(s) and the well aged with low health care costs opting the voucher program. The risk to traditional government benefit programs would be greater.
• Encourages consumer cost consciousness.	
• Allows beneficiaries to change systems at specified and periodic open enrollment periods.	
• Increases the choices available to older individuals in regard to the selection of personal health care plans which can be based on individual needs.	• Places greater responsibility on the aged individual to make informed choices regarding personal health care coverage, which may be unduly difficult for the majority of older Americans.
• Provides the opportunity to integrate the administration of such a program with an existing similar federal program—the Federal Employee Health Benefits System.	• Could be difficult to develop private plans for purchase with a voucher in some less populated areas of the country, thereby limiting chioices for some aged beneficiaries and raising questions of accessibility to health care.
• Makes costs much more predictable for government.	• Encourages the lower income aged who tend to be at greater risk of illness to be underinsured in order to receive a cash refund at the time of purchase of a private plan.
• Provides benficiaries with a reasonable degree of certainty as to their out-of-pocket expenses, even allowing them to supplement the cost of a private plan or realizing a cash bonus for purchasing less expensive plans.	• Needs more study before implementation.
	• Raises the possibility of placing future limitations on the value of the voucher as a means for achieving budgetary reductions. (Voucher would lose value over time).
• Leads to private sector financing of health care for the aged.	• Assumes that the consumer is sufficiently informed about the available alternatives in the complex private health insurance market.
• Increases individual responsibility, thereby fostering independence and self reliance.	
• Encourages prudent use of personal health care services.	• May lack market clout, if voucher is voluntary rather than mandatory.
	• Requires government regulation of qualifying health care plans.

Option 5. Require financial participation by adult children, especially in long term care.

Pro's

- Provides a new or increased source of revenue to finance health care.
- Requires family involvement with the aged parent.

Con's

- May cause anxiety in aged parents and resentment in adult children.
- May have negative public impact.
- Is difficult to administer.
- Has serious legal implications.
- May be difficult to enforce due to geographic distances among family members.
- May be complicated by family dynamics such as estrangement between aged parents and adult children and divorces and remarriages.
- Would not address problem of the high costs of health care.
- May negatively impact the substantial amount of family care already provided to the aged.

Option 6. Establish a national lottery to finance health care for the aged and disabled.

Pro's

- Produces large sums of new revenue to government for use in purchasing an array of health, health-related and social services for the aged.
- Boosts the economy in general and the health care industry in particular.

Con's

- Is a controversial concept.
- Does not insure efficient delivery of health care services.
- Would not address the problem of the high costs of health care.

Option 7. Encourage the development of Preferred Provider Organizations.

Pro's

- Permits greater government control over health care costs.
- Insures lower administrative costs/overhead

Con's

- Restricts beneficiaries' freedom of choice of health care plans and providers.
- Restricts free enterprise.
- Could reduce ready access to care.

Option 8. Advance the age of eligibility for government benefits programs, indexing to life expectancy.

Pro's

- Reduces the beneficiary population and therefore overall government outlays.
- Ties into the changing characteristics of an aging population which has experienced an overall increased life expectancy of three plus years since the inception of Medicare.
- Represents immediate and substantial cost savings to government benefits programs.

Con's

- Widens the gap for midlife and older women who may be uninsured or underinsured.
- Discriminates against minorities who have a shorter life expectancy than their white cohorts.
- Removes protection against illnesses for those who would have otherwise been covered on reaching age 65 and who are unable to afford private insurance.
- May increase costs to government in the long-run due to reduced access to diagnosis and treatment by the "young aged."
- Shifts the burden of health care insurance from government to business/employers for the employed aged.
- Could swell the ranks of the uninsured.
- Could result in disincentives to employers to hire older workers due to insurance costs.

Option 9. Levy or increase federal excise taxes on alcohol and tobacco earmarking the revenues to support health care of the aged.

Pro's

- Places the tax burden on persons whose activities may have necessitated the expenditures.
- Is timely in that federal excise taxes on alcohol have not been increased since the early to mid-fifties and the federal excise taxes currently on cigarettes return to $.08 from the current $.16 effective 10/1/85.
- Generates large sums of new revenue (billions) to support health care for the aged.

Con's

- May have negative impact on states already relying on revenue from state-levied excise taxes on these products.
- Singles out alcohol and tobacco users and is therefore unfair in that the use of other products is also harmful to health.
- May reduce demand for alcohol and tobacco products thereby adversely affecting employment and the economy in general.
- Increases taxation, which is viewed by many as undesirable, unless it replaces the current excise taxes due to be reduced.

Option 10. Encourage states to adopt all-payers systems to control health care costs.

Pro's

- Places responsibility with state governments who already have authority to develop "all payers" systems.
- Resolves issue of cost shifting.
- Allows flexibility so that individual state initiatives can be structured to address local conditions.
- Controls cost upholding quality as demonstrated by all-payer regulatory systems currently operating in Maryland, Massachusetts, New York, and New Jersey.
- Provides uniform cost-control regulations and incentives within each state.
- Improves access to health care by the poor in states with all-payers sytems.

Con's

- Raises the question of government's proper role in health care cost containment. (Should government strictly be responsible only for the programs under its auspices?)
- May lose effectiveness over time.

Option 11. Tax employee-provided health insurance exceeding certain limits and earkmark for health care.

Pro's

- Generates over $20 billion per year in new federal revenues from income taxes to support health care of the aged.
- Represents a progressive form of taxation.
- May result in lower rates of inflation in health care because of increased consumer consciousness regarding the actual costs of medical benefits.
- Increases the wages subject to FICA (Social Security/Hospital Insurance) taxes, thereby further increasing revenues.

Con's

- Has no effect on controlling health care costs and would therefore simply perpetuate and delay the inevitable problems in the delivery of health care services to the aged.
- Does not assure that expected beneficial results in lowering health care costs will actually occur.

Option 12. Encourage all states to enact "natural death" laws with provisions for advance directives and living wills to forego life-sustaining procedures when death is imminent.

Pro's

- Reduces the high costs of medical care for the terminally ill, and ultimately government benefits programs.
- Enables the dying to have greater control over the level and type of care provided in the final stages of life.
- Promotes "death with dignity," even permitting one to die at home if that is the preference.

Con's

- Focuses inappropriately on controlling health care costs; rather, such options should be used to relieve suffering
- Creates opportunity for abuse of the natural death act.

Option 13. Expand prevention-oriented and pre-screening medical benefits to facilitate healthier lifestyles and early detection and treatment for diseases.

Pro's

- Reduces the costs of treatment for those diseases which are diagnosed and treated before they become severe advanced diseases.
- Prevents diseases and thereby reduces spending for personal health care over the long term.
- Improves the health status of the aged in the future.

Con's

- Could potentially increase the immediate costs to government if prevention and screening services are added as reimbursable services.
- Is unsubstantiated by scientific data as a cost-effective means of reducing health care spending, though empirical data would suggest this is true.
- Requires additional research to determine the most effective methods of health promotion.

Option 14. Encourage the development of prepaid capitated plans such as Health Maintenance Organizations

Pro's

- Could reduce government costs to Medicare and Medicaid for aged beneficiaries.
- Allows government to insure better quality assurance by providers.
- Allows providers to have a stronger role in allocating health care resources.
- Increases competition among health care providers for older consumers.
- Emphasizes, provides and promotes preventive care.
- Allows capitated prepayment which makes costs to government much more predictable as well as controllable.
- Reduces out-of-pocket payment for health care.
- Simplifies claim procedures for providers and beneficiaries.
- Maintains quality of care.
- Has ability to provide accessible, comprehensive services and continuity of care.
- Has proven ability (through demonstration process) to reduce hospital admissions.
- Can provide enhanced benefits packages at relatively lower costs.
- Provides for federal certification process for qualifying plans.

Con's

- Represents a new and unfamiliar system of delivering health care to the aged, which may constitute a barrier to access.
- Reduces the aged consumers freedom of choice in selecting health care providers once enrollment in an HMO has taken place.
- Could mean compromised quality of care.
- Causes HMO management problems when eligibility changes frequently and rapid Medicaid enrollee turnover results.
- Increases the risk of adverse selection for the traditional government benefits programs when those with the most health problems elect to continue enrollment rather than to select a capitated payment plan such as an HMO.
- May be difficult to market as HMO's have been rather unpopular with older Americans.
- Would be difficult for many older Americans to sever longstanding relationships with their primary physician.

Option 15. Reallocate the tax rates between the Hospital Insurance Trust Fund and the Old Age and Survivors Insurance and Disability Insurance Trust Funds.

Pro's	Con's
• Diverts surpluses accumulating over the next 25 years in the Old Age and Survivors and Disability Insurance Trust Funds to the HI Trust fund to cover its projected deficits.	• Does not address issue of containing escalating health care costs; postpones.

Option 16. Discontinue or limit funding medical education through Medicare.

Pro's	Con's
• Represents a substantial reduction in Medicare expenditures.	• May reduce the number of health care professionals, especially physicians, over the long term.
• Reduces inappropriate Medicare participation in educating medical professionals seldom trained in geriatric medicine.	

Option 17. Encourage Home Equity Conversion and Reverse Mortgages

Pro's	Con's
• Allows the conversion of assets (over 12 million older Americans are homeowners) into a lifetime stream of income.	• Perpetuates the problem of "overhousing" of the elderly.
• May be used to purchase health including long term care services directly, health or long term care insurance, or to meet other financial needs.	• Fails to address the issue of the high cost of health care.
	• Places the elderly at-risk of depleting home equity during their lifetime and therefore having to relocate.
• Offers psychological and social advantages involving financial independence for many older people.	• Reverses the lifelong goals of attaining a debt-free home - a barrier to some elderly.
• Allows the elderly homeowner to continue living in the familiar surroundings of home.	• Prohibits the elderly from benefitting from property appreciation as monthly annuitites are fixed, based on the appraisal at the time of the transaction.
• Could raise the incomes of at least one fourth of all low income elderly homeowners above the poverty level.	• Could result in transactions made with below-the-market property values placed on homes being converted to cash.
• Offers several options to permit flexibility in local programming.	• Could be costly for the elderly in terms of interest and commissions.
• Provides higher monthly annuities to those groups with a shorter life expectancy (i.e. minorities and males).	• Discriminates against those groups with longer life expectancy by providing lower monthly annuities (i.e. non-minorities and females).

Option 18. Eliminate a separate carrier/intermediary for railroad retirees under Medicare.

Pro's	Con's
• Reduces administrative costs, saving about $10 million from 1986 to 1990.	
• Reduces confusion among the aged regarding this separate administrative structure.	
• Simplifies billing procedures for this group of Medicare enrollees.	

Miscellaneous Proposals

A number of other proposals, many especially applicable to Medicare, have been advanced. These include but are not limited to the following:

1. Freeze prospective payment rates at FY 85 levels for '86.
2. Restructure the Medicare home health benefit.
3. Freeze reimbursement for durable medical equipment under Medicare Part B.
4. Freeze physician fees at FY 85 levels under Medicare.
5. Delay initial Medicare eligibility by one month.
6. Index the Medicare Part B deductible.
7. Modify indirect medical education payments under Medicare.
8. Require a home health co-payment (now 100 percent reimbursable) under Medicare.
9. Freeze reimbursement to clinical laboratories under Medicare.
10. Establish Medicare as secondary payer for working aged over age 69.
11. Freeze payment for direct medical education under Medicare.
12. Freeze limits on skilled nursing facility reimbursement.
13. Simplify Part A Medicare Claims Processing.
14. Increase Part B Medicare premium.
15. Reduce Medicare-funded research.
16. Reduce federal administrative costs of Medicare by a reduction of workforce (equivalent to 180 full-time employees).
17. Increase anti-fraud and financial abuse efforts in Medicare and Medicaid.
18. Encourage alternative reimbursement methodologies, i.e. the physician as broker or financial case manager.
19. Extend Medicare Part B coverage to gerontological nurse practitioner or geriatric clinical nurse services, and other professional nurse services.
20. Add clinical social work services to HMO under Medicare.
21. Require greater coordination of benefits between Medicare and other government programs.
22. Add a Medicare Part B non-smoking discount.
23. Fund medical demonstrations in health promotion and disease prevention to provide data for decision-making on the efficacy of such health services.
24. Structure alternative Medicare benefits and fund demonstration projects designed specifically for individuals with Alzheimer's disease.
25. Prohibit a freeze of physician fees under Medicare Part B.
26. Allow physicians to charge Medicare beneficiaries without regard to the fee freeze if the patient chooses to pay with private sources.
27. Require states to develop and implement coordinated programs for those dually enrolled in Medicare and Medicaid.
28. Provide a household tax deduction for families with an Alzheimer's disease victim.
29. Provide a tax *credit* for families with an elderly member.
30. Levy a cigarette tax and dedicate revenues to the Hospital Insurance Trust Fund (Medicare Part A).
31. Permit the nurse practitioner or clinical nurse to recertify need for physicians services under Medicare.
32. Add hospice services to Medicaid.
33. Rely on interfund borrowing with safeguards for short term financing of Medicare.
34. Expand VA reliance on private sector by increasing contract community nursing home program and use of community resources as alternatives to VA nursing home construction.
35. Increase use of nursing homes for clinical training of health professionals.
36. Establish uniform federal eligibility and benefit levels for the Medicaid program.
37. Combine Medicare Parts A and B and finance as a National Health Insurance Trust Fund from payroll taxes and general revenues.
38. Add a Part C, Long Term Care Services, to Medicare.
39. Encourage consumer participation in all aspects of health care.
40. Encourage private sector health care coalitions.
41. Adopt federal legislation requiring states to develop all-payers health care systems.
42. Encourage states to enact laws limiting the dollar amount of medical malpractice awards.
43. Require the Congressional Budget Office to conduct annual evaluations of national health care costs and issue recommendations.
44. Encourage universities and non-profit foundations to independently assess the nation's health care system and its costs.

45. Consolidate Medicaid and Medicare for the dually enrolled.
46. Subsidize training only for those health care professionals willing to work in underserved areas.
47. Restructure the health care delivery system to emphasize preventive care and community-based services as opposed to institutional care.
48. Limit the annual growth of health care costs to a reasonable percentage in line with the rate of inflation.
49. Require medical malpractice claimants to submit claims to a review panel prior to filing suit.
50. Require employers to offer spouses of employees health insurance coverage—even if the spouses are over age 70. (Under present law, the age limit for such coverage is 69).
51. Phase-out the Hospice Program under Medicare.
52. Establish demonstration health prevention programs to determine the cost effectiveness of such programs.
53. Require all new state and local government employees to pay the hospital insurance portion of the FICA tax.
54. Penalize businesses through denial of a tax deduction for group health plans which fail to offer a continuation option for a widowed spouse and dependent children, divorced or separated spouse and dependent children and/or a spouse who is not eligible for Medicare.
55. Require a second medical opinion for Medicare patients.
56. Use general revenues to support the shortfall in the Medicare Hospital Insurance Trust Fund.

Conclusion

Health care of the aged in America is a dynamic public policy issue with no clear, easy answers to the problems that loom on the horizon. An increased elderly population will be a significant cause of increased health care expenditures beginning about the year 2010. As the health care debate escalates, decision-makers will struggle to balance government regulation, quality, access, freedom of choice, effectiveness, efficiency and equity across the whole fabric of our society.

WHAT SHOULD THE FEDERAL GOVERNMENT DO TO ENHANCE THE QUALITY OF LIFE FOR UNITED STATES CITIZENS OVER AGE 65?

An Annotated Bibliography on the 1988-1989 National High School Debate Topic

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INTRODUCTION

The debate issues relating to the quality of life for the aged are interrelated. Even when the economic security and the health of older individuals seem to be secure, both are vulnerable to the onset of catastrophic or chronic conditions which can jeopardize quality of life. Those who are receiving long-term health care also find themselves needing long-term assistance in "custodial" services, and expenses quickly reduce assets. Recent literature addresses a "continuum of care" as a model for assessing needs and providing social services or financial support. The arrangement of this bibliography reflects this trend.

The bibliography is divided into three sections--Aging; Retirement Security; and A Continuum of Care: Health, Social, and Custodial Services.

The first section provides references on aging in general, on sources of information about the aged in the U.S., on international comparisons, and on issues relating to the quality of life for the aged. Questions of intergenerational equity and on preventive medicince are briefly addressed.

The second section focuses on retirement economic security through public means like Social Security, the Supplemental Security Income Program, other entitlement programs, and taxation; public interest in and regulation of the private system of pensions and other retiree benefits; security for older workers; and personal savings and retirement plans.

The final section explores the continuum of care provided by families, communities, medical personnel, social service network, and institutions when the elderly are unable to care completely for themselves, either because they are functionally or medically dependent on assistance. It includes the role of Federal programs under Medicare, Medicaid, and the Older Americans Act. Finance of long-term care and health care receive particular emphasis.

This bibliography reflects the interrelationship of issues. The reader should scan related sections even if only preparing for one debate focus, in order to be aware of additional variables affecting the security, health, and quality of life of U.S. citizens over age 65. For example, the issue of home equity conversion is listed arbitrarily under the resolve for retirement security, although a primary purpose of turning the homeowner's asset into a source of income is to finance long-term care. Although housing for the aged is listed under the continuum of care as housing alternatives greatly impact the provision of medical, social, and custodial services to the aged, housing is also a large factor in retirement security, both financial and psychological.

AGING--GENERAL

Aaron, Henry J.
When is a burden not a burden? The elderly in America. Brookings review, v. 4, summer 1986: 17-24.
"Suggests that the burdens imposed by an increasing aged population, defined as persons 65 or older, are exaggerated, but that the problems created by the growth in the number of the very old, arbitrarily defined as persons 80 or older, should cause greater concern than they do."

Activities and accomplishments of the Select Committee on Aging, U.S. House of Representatives, 1974-1986: a report. 99th Congress, 2nd session. Washington, for sale by the Supt. of Docs., G.P.O., 1986. 19 p.
At head of title: Committee print.
"Comm. pub. no. 99-597."

Adler, Michele. Kitchen, Suzanne. Irion, Albert.
Databook on the elderly 1987. Submitted by Macro Systems, Inc. [Washington] U.S. Dept. of Health and Human Services, 1987. 259 p.
Partial contents.--Demographic profile.--Health status.--Health care utilization.--Long-term care.--Economic well-being.--Federal expenditures targeted on the elderly.--International comparisons.
Also appears on LOTUS diskettes for use through a personal computer.

Aging--issues and policies for the 1980s. Edited by Ted Tedrick. New York, Praeger, 1985. 243 p.
Based on a conference held at SUNY Brockport in April 1983 to analyze and discuss recommendations from the 1981 White House Conference on Aging.

An aging society: implications for health care needs; impacts on allied health practice and education; a report of the National Task Force on Gerontology and Geriatric Care Education in Allied Health. Journal of allied health, v. 16, Nov. 1987: 283-394.

Aging 2000: our health care destiny. New York, Springer-Verlag, c1985. 2 v.
Edited proceedings of a symposium held Oct. 23-26, 1983 in Houston, Tex.; sponsored by the Texas Research Institute of Mental Sciences.
Contents: v. 1. Biomedical issues.--v. 2. Psychosocial and policy issues.

Alternative budgets for fiscal year 1987: impact on older Americans: an information paper. Prepared by the staff of the Special Committee on Aging, United States Senate. Washington, for sale by the Supt. of Docs., G.P.O., 1986. 50 p. (Print, Senate, 99th Congress, 2nd session, committee print 99-158)
"Serial no. 99-I."

Barrow, Georgia M.
Aging, the individual, and society. St. Paul, West Pub. Co., c1986. 486 p.

Binstock, Robert H.
The aged as scapegoat. Gerontologist, v. 23, Apr. 1983: 136-143.
Examines the current axioms about the aged. Argues that these are "diverting our attention from a variety of deficiencies in political leadership and public policy, . . . engendering intergenerational conflict which may ultimately become rather serious in its implications, . . . and diverting our attention from longstanding issues of reform involving policies that provide benefits to older persons."

Federal policy toward the aging--its inadequacies and its politics. National journal, v. 10, Nov. 11, 1978: 1838-1845.
Argues that Federal programs are not substantially alleviating the economic, health and social problems they were designed to solve.

Brewer, Deborah.
Demographers focus on a changing people. State legislatures, v. 11, July-Aug. 1985: 28-32.
"Perhaps the most significant changes tracked by demographers recently involve accelerated shifts in the way of life of such key groups as youth, the elderly, and women that raise difficult policy questions."

Browne, William P.
Policymaking in the American States: examining institutional variables from a subsystems perspective. American politics quarterly, v. 15, Jan. 1987: 47-86.
"Article examines the policymaking roles and interactions of governors, legislators, administrators, and lobbyists in state politics. It analyzes their policy involvement in terms of whether they fit a conceptual model of subsystem politics. These data are compared to various policy outcome measures of four state governments in the issue area of aging: Florida, Iowa, Michigan, and New Jersey."

Bunten-Mines, Elaine.
Tommorrow's elderly; report prepared by the Congressional Clearinghouse on the Future, for the Select Committee on Aging, House of Representatives, 98th Congress, 2nd session. Washington, G.P.O., 1984. 61 p.
At head of title: Committee print.

Civil rights, affirmative action, and the aged of the future: will life chances be different for Blacks, Hispanics, and women?: a symposium. Gerontologist, v. 26, Apr. 1986: 128-149.
Partial contents.--Antidiscrimination policies today and the life chances of older women tomorrow.--Crystal ball gazing: notes on today's middle aged Blacks with implications for the 21st century.--An examination of factors affecting future cohorts of elderly Hispanics.

Clark, Robert L. Menefee, John A.
Federal expenditures for the elderly: past and future. Gerontologist, v. 21, Apr. 1981: 132-137.
"Briefly summarizes the history of federal programs for the elderly, . . . presents a factor component analysis of the determinants of government spending from 1960 to 1978 using alternative measures of benefit levels, . . . and presents projections of future outlays and the implications of various policy options to maintain an adequate benefit structure for the elderly."

Committee on an Aging Society (U.S.)
Productive roles in an older society. Committee on an Aging Society, Institute of Medicine and National Research Council. Washington, National Academic Press, 1986. 154 p.
"This report . . . presents the papers commissioned for the May 1983 Symposium on Unpaid Productive Roles in an Aging Society."

Cutler, Neal E.
Population dynamics and the graying of America. Urban & social change review, v. 10, summer 1977: 2-5.
Points out that the social, economic, and political attitudes held by today's elderly may not be influenced by their chronological age as much as by their generational experiences. "Not only do individuals age differently, but generations also grow old differently as well."

Damon, Bonnie L. Fowles, Donald G. Taeuber, Cynthia M.
Guide to 1980 census data on the elderly. [Suitland, Md.], U.S. Dept. of the Census; Washington, U.S. Dept. of Health and Human Services, Administration on Aging: For sale by Supt. of Docs., G.P.O. [1986] 571 p.

Death and taxes: the public policy impact of living longer. [Washington] Population Reference Bureau, 1984. 16 p. (Population trends and public policy no. 5)
Analyzes life expectancy trends among the elderly from the perspectives of projecting the size of the elderly population, focusing Federal research dollars on slowing the aging process, and anticipating future Federal costs.

Demkovich, Linda E.
Still no Federal policy on aging, warns Aging Institute's director. National journal, v. 14, July 31, 1982: 1344-1346.

Demographic and social trends: implications for Federal support of dependent-care services for children and the elderly; report prepared by the Congressional Budget Office for the Select Committee on Children, Youth, and Families, House of Representatives, 98th Congress, 1st session with additional views. Washington, G.P.O., 1984. 84 p.

At head of title: Committee print.

"During this decade, a combination of demographic, economic, and social trends will increase the demand for dependent-care services for young children (under age 10) and elderly persons with health problems or functional limitations."

Drew, Joseph.

The dynamics of human services subcontracting: service delivery in Chicago, Detroit, and Philadelphia. Policy studies journal, v. 13, Sept. 1984: 67-89.

Observes that "the use of government subcontracting has developed into a controversial cornerstone of conservative attempts to scale back government." Evaluates "three of the largest human service subcontracting networks delivering services to the elderly in the United States, the Detroit, Chicago, and Philadelphia Area Agencies on Aging."

Economic resources for the elderly: prospects for the future. Edited by Christopher Garbacz. Boulder, Colo., Westview Press, 1983. 236 p.

Elder, Charles D. Cobb, Roger W.

Agenda-building and the politics of aging. Policy studies journal, v. 13, Sept. 1984: 115-129.

Examines the choices that may guide public policy with respect to aging through the study of the agenda-building process--"the process through which problems or issues come to command the active and serious attention of government as prospective matters of public policy."

The Elderly in America. Wilson quarterly, v. 9, Jan. 1985: 94-139.

"Here, Albert Rosenfeld summarizes the latest research on the aging process, and Timothy M. James surveys the culture of the elderly; historian W. Andrew Achenbaum traces the rise of the U.S. government's commitment to the aged." Also includes a list of background books on the elderly in America.

Etheredge, Lynne.

An aging society and the Federal deficit. Milbank Memorial Fund quarterly/health and society, v. 62, no. 4, 1984: 521-543.

"The aged are very much at risk from potential reductions in government assistance."

Fiscal austerity and aging: shifting government responsibility for the elderly. Beverly Hills, Calif., Sage Publications, 1983. 278 p. (Sage library of social research, v. 152)

Partial contents.--Governmental responsibility: issues of reform and federalism.--Social security and Medicare: policy shifts in the 1980s.--Social services: the impact of fiscal austerity.--The Older Americans Act.--Health planning and long term care.--The future for aging and public policy: two perspectives.

Fountaine, Charles. Humphreys, Frederick C., Jr.

An evaluation of the Veterans Administration's geriatric research, education, and clinical centers. Washington, Veterans Administration, 1986. 49 p.

Concludes that "the Geriatric Research, Education, and Clinical Centers Program has made considerable progress in attaining its goal of improving the capacity of the Veterans Administration health care system to meet the medical, psychological, and social needs of older veterans. The program has established an administrative and organizational structure that . . . has resulted in a strong affiliation program with medical schools, training programs for residents, the recruitment of excellent scientists, and the establishment of a policy making advisory group at each GRECC."

Gelfand, Donald E.

The aging network: programs and services. 2nd ed. New York, Springer, 1984. 305 p. (Springer series on adulthood and aging, v. 8)

Partial contents.--The American elderly.--Income maintenance programs.--Programs for the aged.--Services for the aged.--National nonprofit resource groups in aging.

Golant, Stephen M. Rudzitis, Gundars. Daiches, Sol.
Migration of the elderly from U.S. central cities. Growth and change, v. 9, Oct. 1978: 30-35.
"The largest percentage of discretionary program funds for the older population has been allocated and administered in central cities. To the extent that residential shifts redistribute the locational demand for these programs by the elderly consumer, the need to document and understand this group's own migration patterns will be increasingly significant."

Griffith, Jean.
How older Americans live: an analysis of census data; an information paper prepared for use by the Special Committee on Aging, United States Senate. Washington, U.S.G.P.O., 1985. 71 p. (Print, Senate, 99th Congress, 1st session, committee print S. Prt. 99-[illegible])
"Serial no. 99-[illegible]"

Growing old in America: new perspectives on old age. Edited by Beth B. Hess and Elizabeth W. Markson. New Brunswick, N.J., Transaction Books, c1985. 580 p.

Halper, Thomas.
The double-edged sword: paternalism as a policy in the problems of aging. Milbank Memorial Fund quarterly, v. 58, summer 1980: 472-499.
"Outlines a crucial contemporary problem--the institutionalization of the allegedly incompetent 'senile' aged. In that context, the author introduces the term 'inner' paternalism, contending that this form of paternalism represents its most dangerous present-day manifestation."

Handbook on the aged in the United States. Edited by Erdman B. Palmore. Westport, Conn., Greenwood Press, 1984. 458 p.

Health care study for older Americans: a staff report for the Federal Council on the Aging. Washington, U.S. Dept. of Health and Human Services, [1981?] 79 p. (DHHS publication no. (OHDS) 80-20951)
Focuses on demographics and rising health care costs. Discusses public and private sources of payment for health care.

Hudson, Robert B.
The "graying" of the Federal budget and its consequences for old-age policy. Gerontologist, v. 18, Oct. 1978: 428-440.
"Cost-based and competitive political pressures are now emerging which may threaten both the traditional political resources of the aging and the future expansion and liberalization of old age policy benefits. The reasons discussed, the most disadvantaged members of the older population--the old-old, the minority old, and older women--may become the principal victims of these pressures. Public agencies serving the elderly may also be confronted by new and more intense demands."

Jackson, [illegible]
Aged Black Americans: double jeopardy re-examined. In The State of Black America, 1985. 1985 ed. Edited by James Williams. New York, National Urban League, 1985, p. 143-184.

Johnson, Eric W.
Older and wiser: wit, wisdom, and spirited advice from the older generation. New York, Walker, 1986. 202 p.

Kane, Robert, and others.
The future need for geriatric manpower in the United States. New England journal of medicine, v. 302, June 12, 1980: 1327-1332.
"Additional medical manpower will be required to meet the growth in the elderly segment of the United States population over the next 50 years."

Kosterlitz, Julie.
Test of strength. National journal, v. 19, Oct. 24, 1987: 2652-2657.
"As the major player in the 'gray lobby,' the American Association of Retired Persons speaks for millions of members on an increasingly controversial set of public issues."

Krout, John A.
The aged in rural America. Westport, Conn., Greenwood Press, c1986. 220 p. (Contributions to the study of aging; no. 6)

Kutza, Elizabeth A.
Toward an aging policy. Social policy, v. 12, May-June 1981: 39-43.
Focuses on the two concerns of aging policy—"the high cost to society of programs for the elderly and the failure of these programs to address the worst cases."

Lammers, William W.
Public policy and the aging. Washington, Congressional Quarterly, 1983. 265 p.
Partial contents.—Employment, retirement, and pensions.--Health and long-term care.—Policy agenda for the 1980s.

Lockett, Betty A.
Setting the Federal agenda for health research: the case of the National Institute on Aging. Journal of health politics, policy and law, v. 9, spring 1984: 63-80.
"Describes the creation of the National Institute on Aging at the National Institutes of Health, as a case study in 'agenda-building.' . . . This case study illustrates how biomedical research policy evolves when the federal government fails to take the lead in developing an overall strategy, not only for research on aging, but also for all areas of biomedical research."

Longino, Charles F., Jr.
The oldest Americans: State profiles for data-based planning. Coral Gables, Fla., Center for Social Research in Aging, University of Miami, 1986. 244 p.
"A final report for the A.A.R.P. Andrus Foundation."
Provides statistical tables for each State and the District of Columbia profiling characteristics of the population aged 75-84 and 85 and older.

Lubomudrov, Slava.
Congressional perceptions of the elderly: the use of stereotypes in the legislative process. Gerontologist, v. 27, Feb. 1987: 77-81.
"Examined is the role of misperceptions in a Congressional debate about politics for the aging. Found was that misperceptions about the elderly, in the guise of compassionate stereotypes, were frequently expressed in these debates. Legislators who voiced such stereotypes were also the most likely to speak and to vote against proposals to reduce Social Security benefits. Some evidence was also found for the expression of positive stereotypes and factually correct information."

Morrison, Peter A.
Changing family structure: who cares for America's dependents? Santa Monica, Calif., Rand, 1986. 18 p.
"N-2518-NICHD"
"Reviews several ongoing demographic changes in families and considers their implications for legislation. Those changes include the growing instability of contemporary families; their increasingly diverse, often nontraditional, forms; the altered social settings and economic circumstances affecting children; and the lengthening of life expectancy among other Americans."

Nagel, Stuart S.
Political science applied to aging policy. Policy studies journal, v. 13, Sept. 1984: 197-203.
"Shows the relevance of all fields of political science to public policy toward the elderly."

Nelson, Gary.
Social class and public policy for the elderly. Social service review, v. 56, Mar. 1982: 85-107.
"Hypothesizes that public policy targets benefits to three classes of elderly: the poor or marginal elderly, the middle- and lower-middle-class downwardly mobile elderly, and the middle- and upper-middle-class high-income elderly. It is suggested that public policy for the elderly serves as an intervening variable or mechanism which helps to ensure status maintenance in old age. It is argued, in conclusion, that public policy for the elderly must be redirected to emphasize a redistribution of benefits from an elite of high-income elderly to the poor and near-poor elderly."

Neugarten, Bernice L., ed. Havighurst, Robert J., ed.
Extending the human life span: social policy and social ethics. [Chicago] Committee on Human Development, University of Chicago [for sale by the Supt. of Docs., G.P.O., 1977] 70 p.

Partial contents.--Perspectives on human longevity.--Prospects of lengthening life and vigor.--Extension of the active life: ethical issues.--The aging society and the promise of human life.

Old age: environmental complexity and policy interventions. Journal of social issues, v. 36, no. 2, 1980: 1-192.

Partial contents.--Aging labels: the decline of control and the fall of self-esteem.--Rural-urban differences among the elderly: economic, social, and subjective factors.--Toward a continuum of caring alternatives: community based care for the elderly.

Old age in a bureaucratic society: the elderly, the experts and the state in American history. Edited by David Van Tassel and Peter N. Stearns. Westport, Conn., Greenwood Press, c1986. 259 p. (Contributions to the study of aging, 0732-085X; no. 4)

Oriol, William E.
Redefining the new federalism: impact on low-income and other older Americans: a report based upon a national assembly conducted by the National Council on the Aging, June 28-29, 1983, Washington, D.C. Washington, The Council, c1983. 183 p.

Our aging society: paradox and promise. Edited by Alan Pifer and Lydia Bronte. New York, W. W. Norton, c1986. 438 p.

Perspective on aging: in the national interest . . . public policy agenda, 1986-1987. Washington, National Council on the Aging, 1986. 64 p.

Makes public policy recommendations for social security, health care, long-term care, housing, community services, jobs and pensions, enriching life, and special concerns.

Planning for the elderly. Philadelphia, American Academy of Political and Social Science, 1978. 107 p. (American Academy of Political and Social Science, Philadelphia. Annals, v. 438)

Partial contents.--The aging of the family.--The aging of America: questions for the four-generation society, by J. Califano, Jr.

Portnoi, Valery A.
The natural history of retirement. JAMA [Journal of the American Medical Association], v. 245, May 1, 1981: 1752-1754.

Asserts that "despite the common belief, held by the medical community and lay persons alike, that retirement has a profound negative impact on the health of the retired person, available scientific data indicate that retirement per se may have a positive or no effect on health. New medical philosophy and approaches to retirement are suggested after review of the literature pertaining to the relationship between health, life satisfaction, and retirement."

Public policy, the private nonprofit sector and the delivery of community-based long term care services for the elderly; final report. San Francisco, Aging Health Policy Center, University of California, 1983. 2 v.

Volume 2 is an executive summary of the final report.

Presents an analysis of a 1983 telephone survey of mainly private nonprofit community-based service providers and of private and nonprofit funders of these agencies, conducted in eight states and 32 communities. Examines the "fate of the community-based systems" for long term care services to the elderly (not institutional care) with respect to their facing cutbacks in Federal funds; having to compete with State and local governments and each other for Federal and private funding; and the growing competition with proprlietary providerrs in some service aresas.

Readings in the political economy of aging. Edited by Meredith Minkler and Carroll L. Estes. Farmingdale, N.Y., Baywood Pub. Co., c1984. 278 p. (Policy, politics, health, and medicine series; 6)

Report on the status of midlife and older women in America. Washington, Older Women's League, 1986. 8 p.

Partial contents.--Income and poverty status.--Marital status, living arrangements, and housing.--Employment status and history.--Health care access.--Family caregiving.--About OWL.

Research advances in aging, 1984-1986. Bethesda, Md., National Institute on Aging, 1987. 40 p. (NIH publication no. 87-2862)

Rhine, Shirley H.
America's aging population: issues facing business and society. [New York] Conference Board [1980] 60 p. (The Conference Board. Report no. 785)
"This report concludes with a number of policy options that call for study in the years immediately ahead. Particular emphasis is placed on the need for planning now for the huge increase in the numbers of older persons between the years 2010 and 2030. Policymakers in both the private and public sectors will be reassessing retirement policies, pension policies, social security legislation, and other influences that impinge on retirement decisions and on the costs of supporting the nonworking elderly population."

Riche, Martha Farnsworth.
Retirement's lifestyle pioneers. American demographics, v. 8, Jan. 1986: 42-44, 50, 52-54, 56.
Finds today's elderly are more numerous and have different lifestyles from previous generations. "The first older generation in history to have substantial retirement income, today's elderly are using their money first and foremost to end the centuries-long practice of spending their remaining years in their children's homes."

Rosenwaike, Ira.
The extreme aged in America: a portrait of an expanding population. Westport, Conn., Greenwood Press, 1985. 253 p. (Contributions to the study of aging, 0732-085X; no. 3)

Siegel, Jacob S. Davidson, Maria.
Demographic and socioeconomic aspects of aging in the United States. Washington, U.S. Bureau of the Census, for sale by the Supt. of Docs., G.P.O., 1984. 10, 149 p. (Current population reports. Special studies, series P-23, no. 138)
Analyze "data on selected topics related to the demographic and socioeconomic aspects of aging and the demographic and socioeconomic characteristics of the older population in the United States. Discuss "the numbers and proportions of older persons; age, sex, and race composition; geographic distribution and residential mobility; mortality, survival, and health; and various social and economic characteristics, including marital status and living arrangements, educational level, work status, and income."

Social policy, social ethics, and the aging society. Chicago, Committee on Human Development, University of Chicago, for sale by the Supt. of Docs., G.P.O., [1976] 121 p.
"NSF/RA 76-000247"
Report of a conference organized by a group of faculty members at the University of Chicago.
Partial contents.--United States social policy on old age: present patterns and predictions.--Federal economic policy toward the elderly.--The ethics of providing for the economic well-being of the aged.

Soldo, Beth J.
America's elderly in the 1980s. [Washington] Population Reference Bureau, 1980. 48 p. (Population bulletin, v. 35, no. 4, Nov. 1980)
Partial contents.--Demography of today's elderly.--Quality of Life.--Help for the elderly.--Initiatives for change: challenges of an aging society.--Aging in international perspective.

The Status of the Black elderly in the United States; a report by the National Caucus and Center on Black Aged, Inc. for the Select Committee on Aging, House of Representatives, 100th Congress, 1st session. Washington, G.P.O., 1987. 68 p.
At head of title: Committee print.
"Comm. pub. no. 100-622"

Storey, James R.
Older Americans in the Reagan era: impacts of Federal policy changes. Washington, Urban Institute Press, c1983. 48 p. (Changing domestic priorities series)
"Provides information on the nature and size of the elderly population, their financial circumstances, and their degree of reliance on public services; charts the course and consequences for older Americans of those

federal policy changes since 1980 that particularly affect them; and discusses the major relevant proposals in the president's fiscal year 1984 budget, including the bipartisan plan to resolve the financial crisis facing the Social Security system."

Survey of aging veterans: a study of the means, resources, and expectations of veterans aged 55 and over, conducted for The Veterans Adminstration. [New York?] Louis Harris and Associates, Inc., 1984. 1 v. (various pagings)
"December 1983., Study No. 823006."

Taeuber, Cynthia M.
America in transition: an aging society. Washington, U.S. Bureau of the Census, for sale by the Supt. of Docs., G.P.O., 1983. 28 p. (Current population reports, series P-23, no. 128)
"Presents a compendium of facts brought together to provide a readily usable profile of the demographic, social, and economic circumstances of the older members of American society."

Technology and aging in America. Washington, U.S. Office of Technology Assessment, for sale by Supt. of Docs., G.P.O., [1985] 496 p.
"OTA-BA-264"

Torres-Gil, Fernando M.
Politics of aging among elder Hispanics. Washington, University Press of America, c1982. 211 p.
Revision of thesis (Ph. D.)--Brandeis University, 1976.

Tropman, John E.
Public policy opinion and the elderly, 1952-1978: a kaleidoscope of culture. New York, Greenwood Press, 1987. 247 p. (Contributions to the study of aging, no. 6)

U.S. Community Services Administration. Office of Policy, Planning and Evaluation.
Policy issues for the elderly poor. Washington, 1981. 121 p. (CSA pamphlet 6172-8)
Partial contents.--The measurement of poverty: the case of the elderly.--Determinants of nonparticipation of low income elderly in income security programs.--Rising fuel prices and low-income elderly homeowners: an analysis of public policy, programs and options.--The impact of Federal health care policy on the elderly poor: the special case of the Black elderly.--The rural elderly poor: economic impacts and policy issues.--Beyond policies of rectification: the need for a comprehensive assessment of the elderly poor.

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Human Resources.
Oversight hearing on the Older American Volunteer programs, foster grandparent, senior companion, and RSVP. Hearing, 99th Congress, 1st session. Oct. 29, 1985. Washington, G.P.O., 1986. 58 p.
"Serial no. 99-80"

U.S. Congress. House. Select Committee on Aging.
The politicization of the 1981 White House Conference on Aging: a report. 98th Congress, 2nd session. Washington, G.P.O., 1984. 140 p.
At head of title: Committee print.
"Comm. pub. no. 98-459"

Problems of aging women. Hearing, 97th Congress, 2d session. Washington, G.P.O., 1982. 157 p.
"Comm. pub. no. 97-363"
Hearing held on July 26, 1982, Omaha, Neb.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Federal, State and Community Services.
Aging in the world of tomorrow (part I). Hearing, 95th Cong., 1st sess. Sept. 27, 1977. Washington, G.P.O., 1977. 71 p.
"Comm. pub. no. 95-108"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Human Services.
Future directions for aging policy: a human service model; a report. Washington, G.P.O., 1980. 141 p.
At head of title: Committee print.
"Comm. Pub. no. 96-226"

Life extension and tomorrow's elderly. Hearing, 95th Congress, 2nd session. Feb. 8, 1978. Washington, G.P.O., 1978. 79 p.
"Comm. Pub. no. 95-127"

U.S. Congress. Joint Economic Committee. Subcommittee on Economic Resources, Competitiveness, and Security Economics.
Demographic changes in the United States: the economic and social consequences into the 21st century. Hearings, 99th Congress, 2nd session. Washington, G.P.O., 1987. 534 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-1088)
Hearings held July 25, 29, and 31, 1986.

U.S. Congress. Senate. Committee on Governmental Affairs. Subcommittee on Energy, Nuclear Proliferation, and Government Processes.
Statistical policy for an aging America. Joint hearing before the Subcommittee on Energy, Nuclear Proliferation, and Government Processes of the Committee on Governmental Affairs and the Subcommittee on Aging of the Committee on Labor and Human Resources, United States Senate, 99th Congress, 2nd session. June 3, 1986. Washington, G.P.O., 1986. 661 p. (Joint hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-858)

U.S. Congress. Senate. Committee on Labor and Human Resources. Subcommittee on Aging.
Longevity and the lifestyle of the older individual. Hearing, 98th Congress, 2nd session. Sept. 27, 1984. Washington, G.P.O., 1984. 109 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-1138)

U.S. Congress. Senate. Select Committee on Aging.
Developments in aging: 1983; a report pursuant to S. Res. 76, March 2, 1983, resolution authorizing a study of the problems of the aged and aging. Washington, G.P.O., 1984. 2 v. (Report, Senate, 98th Congress, 2nd session, no. 98-360, v. 1-2)

U.S. Congress. Senate. Special Committee on Aging.
America in transition: an aging society, 1984-85 edition; an information paper. Washington, G.P.O., 1985. 98 p. (Print, Senate, 99th Congress, 1st session, committee print S. Prt. 99-55)
"Serial no. 99-B"

Developments in aging: 1985 (volume 3); a report . . . pursuant to S. Res. 85, Sec. 19, February 28, 1985 resolution authorizing a study of the problems of the aged and aging. Washington, G.P.O., 1986. 98 p. (Report, Senate, 99th Congress, 2nd session, no. 99-242, vol. 3)
Contents.--Size and growth of the older population.--Geographic distribution and mobility.--Economic status.--Retirement trends and labor force participation.--Health status and health services utilization.--Social characteristics.--Federal outlays benefiting the elderly.

Developments in aging: 1986; report. Vol. 3. Washington, G.P.O., 1987. 126 p. (Report, Senate, 100th Congress, 1st session, no. 100-9, Vol. 3)

The proposed fiscal year 1988 budget: What it means for older Americans. Hearing, 100th Congress, 1st session. Mar. 13, 1987. Washington, for sale by the Supt. of Docs., G.P.O., 1987. 468 p. (Hearing, Senate, 100th Congress, 1st session, S. hrg. 100-113)
"Serial no. 100-3"

U.S. Federal Council on the Aging.
Annual report to the President, 1986. Washington, The Council, 1987. 24 p. (U.S. Dept. of Health and Human Services. DHHS publication no. (OHDS) 87-20824)

Partial contents.--Growing phenomenon of local private foundations as funding sources of senior programs.--Self-health maintenance information and survey issues.--Home equity insurance and non-profit organization trusts as housing factors.--FCA hearing on native Americans concerns for tribal elders.--1987 reauthorization of the Older Americans Act recommendations. --Organizations and funding of a national conference on aging.

Policy issues concerning the elderly minorities. Washington, 1979 [i.e. 1980] 72 p. (U.S. Dept. of Health and Human Services. DHHS publication no. (OHDS) 80-20670)

U.S. General Accounting Office.

Aging: GAO activities in fiscal year 1987; report to the chairman, Special Committee on Aging, U.S. Senate. Dec. 15, 1987. Washington, GAO, 1988. 37 p.

"GAO/HRD-88-42; B-217195"

Provides an annotated list of GAO reports audits, and activiites affecting the elderly.

An aging society: meeting the needs of the elderly while responding to rising Federal costs; report to the chairman, Subcommittee on Intergovernmental Relations and Human Resources, Committee on Government Operations, House of Representatives. Sept. 30, 1986. Washington, GAO, 1986. 70 p.

"GAO/HRD-86-135; B-223880"

Explores the relationship of projected demographic changes to the economic and health care status of the elderly. Assesses the potential impact of changes in Federal health and retirement programs on the needs of the elderly.

U.S. Interdepartmental Working Group on Aging. Task Force on Statistics.

Inventory of Federal statistical programs relating to older persons. [Washington] For sale by the Supt. of Docs., G.P.O., 1979. 113 p. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (OHDS))

"This book is an attempt to gather into one place all federal surveys and programs containing data related to the elderly population. This resource document will thus serve as a means for persons and organizations in the field of aging to keep abreast of the changing characteristics of the elderly population."

U.S. President's Commission on Mental Health. Task Panel on the Elderly.

Mental health and the elderly: recommendations for action. Washington, U.S. Federal Council on the Aging, for sale by the Supt. of Docs., G.P.O. [1979] 126 p. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (OHDS) 80-20960)

"The publication contains in one document the reports of the two major public advisory bodies which during the period 1976-1978 studied and conducted hearings on the issue of the mental health needs of the elderly and developed recommendations for public policy to address these needs."

Villers Foundation.

On the other side of easy street: myths & facts about the economics of old age; a report. Washington, The Foundation, c1987. 66 p.

Seeks to "sort out fact from fiction, reality from mythology, about the economics of old age.

White House Conference on Aging, Washington, D.C., 1981.

Final report. [Washington, 1982?] 2 v.

Contents.--V. 1. National policy on aging.--V. 2. Process proceedings.--V. 3. Recommendations, post-conference survey of delegates.

Report of Technical Committee on Creating an Age Integrated Society: implications for governmental structures. [Washington] 1981. 67 p.

"This paper addresses the interaction between government structure and aging policy and administration. The technical committee focused on three general areas: the role of government--the nature of its responsibility and policies regarding older citizens, the strategies which should be considered to achieve national objectives, and the most effective, efficient and responsive structures for delivery of needed services."

Report of Technical Committee on Creating an Age Integrated Society: implications for the family. [Washington] 1981. 51 p.
Report examines the changes which have taken place in recent years in family structure, interactions, and expectations. It looks at the implications of these changes for policy, practice, and research in an age-integrated society.

Report of Technical Committee on Research in Aging. [Washington] 1981. 57 p.
"Research on aging touches upon the most fundamental issues of human existence--not only in terms of the biological factors which make life possible, but also the social conditions that make life meaningful. In essence, it embraces research in the biological, psychological and social sciences, and extends to applications of that research designed to improve the quality of life for older adults."

Report of Technical Committee on the Physical & Social Environment and Quality of Life. [Washington] 1981. 52 p.
Discusses the following issues: quality of life, housing, transportation, crime, legal services, the arts and humanities, and the creative use of time.

Williams, Blanch Spruiel.
Characteristics of the Black elderly--1980. [Washington] National Clearinghouse on Aging, 1980. 41 p. (U.S. Dept. of Health and Human Services. DHHS publication no. (OHDS) 80-20057)

Zopf, Paul E.
America's older population. Houston, Cap and Gown Press, c1986. 325 p.

ENHANCING THE QUALITY OF LIFE THROUGH HEALTH PROMOTION AND PREVENTIVE MEDICINE

Butler, Robert N.
Clinical, needs assessment studies can benefit research on aging. Hospitals, v. 55, Apr. 16, 1981: 94-96, 98.
"Hospitals can participate in the research that will make possible improvements in preventive, therapeutic, and diagnostic medicine for the elderly."

Hallowell, Christopher.
Growing old, staying young. New York, Morrow, c1985. 309 p.

Heckler, Margaret M.
Health promotion for older Americans. Public health reports, v. 100, Mar.-Apr. 1985: 225-230.
Reports that "the Department of Health and Human Services, through its many component agencies, has inaugurated a major initiative to promote health and fitness among older Americans to improve life quality and to reduce health care costs." Also identifies six target areas of concentration: "fitness-exercise, nutrition, safe and proper use of drugs and alcohol, accident prevention, other preventive services, and smoking cessation." State and local government and private sector cooperative programs are also discussed.

Rogers, John.
Proposed evaluation criteria for screening program for the elderly. Gerontologist, v. 26, Oct. 1986: 564-570.
"Screening programs for the elderly are receiving greater attention due, in part, to the increase in the number of elderly in the population, the escalating costs of health care for the elderly, the continued loss of potential years of life, and the prevalence of functional disability in the elderly due to chronic problems . . . . To critically evaluate these types of programs, standard criteria developed for primary and secondary prevention efforts cannot simply be adopted. Instead, criteria that reflect the health goals for this age group need to be promulgated and applied to current and future programs. Several criteria have been proposed in this paper, and their application to a screening program for the elderly has been presented."

Rosenwaike, Ira. Yaffe, Nurit. Sagi, Philip C.
The recent decline in mortality of the extreme aged: an analysis of statistical data. American journal of public health, v. 70, Oct. 1980: 1074-1080.
"The results of the analysis indicate that substantial real reduction in mortality has occurred among the elderly population . . . . A sharp downturn in the age-adjusted rates for the cardiovascular diseases, which are more common among the aged, appears to account for the relatively greater reduction in mortality in this age group."

Southern Regional Education Board. Commission on Health and Human Services.
Recommendations: health professions education; a report to the Southern Regional Education Board by its Commission. Atlanta, The Board, 1986. 10 p.
Recommends action by State governments to respond to problems facing the health professions schools and academic health centers, including the need to stress geriatrics, gerontology and clinical prevention in the curricula.

Stiedemann, Mary. Jansen, Coerene. Harrill, Inez.
Nutritional status of elderly men and women. Journal of the American Dietetic Association, v. 73, Aug. 1978: 132-139.
"Although nutritional care represents a major portion of preventive rehabilitative needs of the elderly, few studies have provided data which permit a comparison of the nutritional status of elderly men and women, particularly the institutionalized elderly." In this study the authors compare daily intakes of energy and nutrients for 23 pairs of elderly men and women living in nursing homes.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Preventive health care for the elderly. Hearing before the Subcommittees on Health and Long-Term Care and Federal, State, and Community Services of the Select Committee on Aging, House of Representatives, 94th Congress, 2nd session. Apr. 14, 1976. Washington, U.S. G.P.O., 1976. 71 p.

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health.
Health promotion--disease prevention. Hearing, 99th Congress, 1st session. June 14, 1985. Washington, G.P.O., 1985. 370 p. (Hearing, Senate, 99th Congress, 1st session, S. Hrg. 99-260)

Wan, Thomas T. H.
Well-being for the elderly: primary preventive strategies. Lexington, Mass., Lexington Books, c1985. 190 p.

White House Conference on Aging, Washington, D.C., 1981.
Report of Technical Committee on Health Maintenance & Health Promotion. [Washington] 1981. 88 p.
"A health care system that waits for health to fail before acting is clearly inadequate and cannot help being enormously expensive. The Health Maintenance and Health Promotion Technical Committee favors a far more active approach with increased emphasis on promoting wellness, on favoring preventive care, on finding ways to keep the elderly in their own homes and communities with maximum independence and freedom of movement rather than institutionalizing them."

INTERGENERATIONAL EQUITY

Clark, Robert. Spengler, Joseph.
Population aging in the twenty-first century. Aging, no. 279-280, Jan.-Feb. 1978: 6-13.
Concludes that "given a slowly growing or near stationary population, life extension increases intergenerational economic conflict."

Kingson, Eric R.
Ties that bind: the interdependence of generations, by Eric R. Kingson, Barbara A. Hirshorn, and John M. Cornman. Cabin John, MD., Seven Locks Press, 1986. 195 p.
"A report from the Gerontological Society of America."

The common stake: the interdependence of generations, by Eric R. Kingson, Barbara A. Hirshorn, and Linda K. Harootyan. Washington, Gerontological Society of America [1986] 30 p.

"Summarizes the major points about an aging society that need to be understood to frame and analyze associated issues properly, and it then discusses two approaches to framing policies in light of these points." The intergenerational inequity approach "frames policy issues in terms of competition and conflict between young and old over the distribution of scarce resources. . . . The interdependence of generations approach . . . recognizes that the reciprocity of giving and receiving among individuals and generations over time is critical to social progress."

Kosterlitz, Julie.
Who will pay? National journal, v. 18, Mar. 8, 1986: 570-574.

Cautions that "the ranks of retirees will be swollen by baby boomers who will draw benefits for more years. As the ratio of retirees to baby bust workers grows, social security's pay-as-you-go concept could be severely strained."

Longman, Phillip.
Born to pay: the new politics of aging in America. Boston, Houghton Mifflin, 1987. 308 p.

Ozawa, Martha N.
The 1983 amendments to the Social Security Act: the issue of intergenerational equity. Social work, v. 29, Mar.-Apr. 1984: 131-137.

"Reviews the conditions that prevailed before the passage of the 1983 amendments to the Social Security Act, the probable effects of the amendments, and the future direction of social security."

A Symposium on measuring hardship among older Americans during the first four years of the Reagan Administration. Gerontologist, v. 26, Feb. 1986: 25-62.

The articles "describe policy changes and the distribution of program cuts; . . . examine the effects of the economy and of federal tax and expenditure policy on the incomes of the elderly; . . . develop and apply more direct measures of well-being in the areas of food, housing, access to medical care, and support systems; . . . look at how elderly public aid recipients fared in comparison to non elderly public assistance recipients; . . . and examine the issue of whether inequality in income is greater among the elderly."

U.S. Congress. House. Select Committee on Aging.
Threats today against tomorrow's social security retirees. Hearing, 98th Congress, 1st session. Mar. 8, 1983. Washington, G.P.O., 1983. 73 p.
"Comm. pub. no. 98-383"

Wynne, Edward A.
Will the young support the old? Society, v. 23, Sept.-Oct. 1986: 40-47.

"Raises the question of whether our young are being taught to honor and respect the elderly for the sacrifices they have made on their behalf; whether they are being imbued with a sense of duty; and whether they are developing an understanding of the importance of economic productivity and diligence."

INTERNATIONAL PERSPECTIVES ON AGING

Aging and rehabilitation. Rehabilitation/WORLD, v. 8, winter 1984-85: 4-17, 19-33, 41-51.

Partial contents.--An aging America: how will it affect rehabilitation?--Merging rehabilitation and aging policies and programs.--Benefit and cost analysis in geriatric care: turning age discrimination into health policy.--Latin American survey on the elderly.--The Israeli experience.--On Lok.--A Chinese nursing home.--Innovative programs abroad.--Resource list for aging.

Cowgill, Donald O.
Aging around the world. Belmont, Calif, Wadsworth Pub. Co, c1986. 227 p.

Demographic development and social security. Geneva, International Labour Office, 1987. 100 p.

Partial contents.--Population and social security in Europe, 1985-2025.--

Social security measures designed to support and strengthen the family.--Income maintenance for the elderly: the influence of demographic change.--The aging of the population in Europe and the cost of medical care.

Growing old in the future: scenarios on health and ageing, 1984-2000. Edited by C. F. Hollander and H. A. Becker; scenario-report commissioned by the Steering Committee on Future Health Scenarios; translation from Dutch by C. N. ter Heide-Lopey. Dordrecht, Boston, Nijhoff, 1987. 305 p.

Heller, Peter S. Hemming, Richard.
Aging and social expenditure in major industrial countries. Finance & development, v. 23, Dec. 1986: 18-21.
"In this paper it has been shown that as long as social programs are organized along their present lines, population aging will intensify the pressure of demand for government social expenditure. This is particularly the case in the context of the other factors which have historically led to a growth in real benefits and costs at rates in excess of the growth in productivity. The resulting increase in the tax burden may demand a policy response. There is probably scope for social expenditure to be contained."

Aging and social expenditure in the major industrial countries, 1980-2025, by Peter S. Heller, Richard Hemming, and Peter W. Kohnert. Washington, International Monetary Fund, 1986. 76 p. (Occasional paper no. 47)
Partial contents.--Pensions.--Medical care.--Unemployment compensation, family benefits, and other social programs: projections and policy issues.
"Reviews the key policy issues likely to emerge, both at an aggregate and a sectoral level, and the types of policies countries have initiated in trying to cope with the effects of these demographic trends." The Group of Seven Countries studied are Canada, the Federal Republic of Germany, France, Italy, Japan, the United Kingdom, and the United States.

International perspectives on long-term care. Edited by Laura Reif, and Brahna Trager. New York, Haworth Press, c1985. 341 p.
"Has also been published as Home health care services quarterly, volume 5, numbers 3/4, fall 1984/winter 1984/85."

Martin, Linda G.
Japanese response to an aging labor force. Population research and policy review, v. 1, Jan. 1982: 19-41.
"Slowing population growth in Japan has led to concern about aging of the labor force in the context of the seniority wage and lifetime employment systems. There is no question that the labor force will age rapidly in the future." However, the "Japanese government and private enterprises are devising innovative policies for accommodating an older labor force."

Nationalizing social security in Europe and America. Edited by Douglas E. Ashford, and E. W. Kelley. Greenwich, Conn., JAI Press, c1986. 291 p. (Monographs in organizational behavior and industrial relations; v. 4)

Ogawa, Naohiro. Suits, Daniel B.
Retirement policy and Japanese workers: some results of an opinion survey. International labour review, v. 122, Nov.-Dec. 1983: 733-746.
Examines "Japanese employees' reactions to a variety of proposed retirement arrangements, some of them involving a raising of the age of compulsory retirement. In addition, we shall arbitrarily select France to consider differences in workers' responses between the two countries."

Organization for Economic Cooperation and Development.
Socio-economic policies for the elderly. Paris, 1979. 168 p.
Partial contents.--Analytical framework and demographic data.--Aging workers, employment and retirement.

Pearce, Fred.
Welcome to the global old folks' home. New scientist, v. 115, July 9, 1987: 32-35.
Discusses demographic projections on birth rates and the number of people over 65 in the future.

Personal social services and the private sector. London, Policy Studies Institute, 1987. 74 p. (PSI discussion paper no. 15)
Partial contents.--Increasing private provision of social care: a

director's view.--Increasing private provision of social care: implications for policy.--The regulation of private social care.--The growth of private nursing homes in Australia: lessons to be learnt.

Shuman, Tarek.
The aging of the world's population. Ambio, v. 13, no. 3, 1984: 175-181.
"Due to the combined fluctuations in fertility, life expectancy at birth, and mortality, the average age of the world's population is expected to increase dramatically within the next forty years. By 2025 the number of people in the world 60 years of age and older will top the one billion mark. The aging of the world's population raises critical economic, social and political questions, especially in the developing countries, where the transition from a currently youthful population to an aging one will occur much more rapidly than it has in more developed countries."

Social security and the elderly: background document prepared for the World Assembly on Aging by the International Social Security Association. International social security review, v. 35, no. 4, 1982: 489-527.
Summarizes "the lessons that can be drawn from the practice of social security institutions as to the over-all contribution that social security can make to national policies for older people."

Torrey, Barbara Boyle. Kinsello, Kevin. Taeuber, Cynthia M.
An aging world. Washington, U.S. Bureau of the Census, for sale by the Supt. of Docs., G.P.O., 1987. 85 p. (International population reports series P-95, no. 78)
Summarizes "detailed demographic and socioeconomic statistics that have been collected on older populations in 31 countries . . . . The world's elderly population currently is growing at a rate of 2.4 percent per year. There are 290 million elderly persons (aged 65 and over) now, and it is expected that there will be 410 million worldwide by the year 2000."

United Nations. Secretary-General.
First review and appraisal of the implementation of the International Plan of Action on Aging; report. New York United Nations, 1984. 58 p. (Document E/1985/6)
At head of title: United Nations Economic and Social Council.
Partial contents.--The aging of the world's population: demographic trends during the 1980s.--Policies and programmes on aging since the World Assembly on Aging: national, regional and international responses.--The aging of populations and socio-economic development.--Humanitarian implications of growth in the elderly population.--Promotion policies and programmes.--Conclusions of the review and appraisal exercise.

U.S. Social Security Administration.
Social security in a changing world. Washington, 1979. 136 p. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (SSA) 79-11948)
Partial contents.--Social security: a worldwide issue.--Sources of revenue of social security systems in 10 industrial countries.--Impact of an aging population on social security: the foreign experience.--Social security benefits for women in the Federal Republic of Germany, Switzerland, and the United Kindgom.

Zabalza, A. Piachaud, D.
Social security and the elderly: a simulation of policy changes. Journal of public economics, v. 16, Oct. 1981: 145-169.
"Investigates the labour supply effects and the corresponding financial implications that would result from some specific changes in the British social security system . . . . These are: raising the state retirement pension, abolishing the earnings rule, changing the statutory pensionable age and introducing a system of flexible retirement. We find that, of the four policy changes considered, the last two would have the largest labour supply effects.

RETIREMENT SECURITY--GENERAL

Anderson, Kathryn H. Burkhauser, Richard V. Quinn, Joseph F.
Do retirement dreams come true? The effect of unanticipated events on retirement plans. Industrial and labor relations review, v. 39, July 1986: 518-526.

"Analyzing data from the Retirement History Study, the authors find that the retirement plans of male workers aged 58-63 in 1969 were significantly affected by unanticipated events over the next decade. Specifically, unanticipated increases in Social Security wealth induced retirement earlier than originally planned, as did deterioration in personal health, whereas the recession of the 1970s tended to delay retirement. This evidence that policy changes do affect retirement behavior in systematic ways provides support for the decision by Congress to defer until the turn of the century the application of several important provisions of the 1983 amendments to the Social Security Act."

Assaf, Michael V., Jr.
Retirement income policy. Employee benefits journal, v. 11, Sept. 1986: 19-21.

Examines and comments on the "ten-point declaration of policy" which serves as the premise for the provisions of the Retirement Income Policy Act.

Boskin, Michael J. Shoven, John B.
Concepts and measures of earnings replacement during retirement. Cambridge, Mass., National Bureau of Economic Research, 1984. 36 p. (Working paper no. 1360)

"This paper compares the well-being of the Retirement History Survey of the elderly with their own previous levels of income and economic welfare. Traditional replacement rates are calculated, although a number of shortcomings of such measures are discussed. Modifications are made by examining career average rather than peak earnings, by adjusting for the fact that the incomes of the elderly are taxed more lightly, that the elderly do not have dependent children, and that Social Security income in retirement is a safer source of income than earnings earlier in life. The fully adjusted total income measures are at least as high for almost all classes of households in the survey as their career average pre-retirement earnings."

Clark, Robert L. Barker, David T.
Reversing the trend toward early retirement. Washington, American Enterprise Institute for Public Policy Research [1981] 64 p. (Studies in social security and retirement policy; AEI studies 316)

Partial contents.--Public expenditures on the elderly and the costs of early retirement.--Increasing propensity toward early retirement.--The retirement decision.--The future of retirement patterns.--Retirement policy reform.

Controversy over mandatory retirement policy: pro & con. Congressional digest, v. 61, no. 11, 1982: 257-288.

Ebel, Roland H. Wagoner, William. Hrubecky, Henry F.
Get ready for the L-bomb: a preliminary social assessment of longevity technology. Technological forecasting and social change, v. 13, Feb. 1979: 131-148.

"The study will attempt to determine the effects of longevity technology upon the social impact variables within the framework of five basic working lifetime scenarios as follows: (1) normal working lifetime, (2) extended working lifetime, (3) delayed working lifetime, (4) segmented working lifetime, and (5) divided working lifetime."

Economic decisions of families: security for the elderly and labor force participation of women: proceedings of a workshop, Edgewood College, Madison, Wisconsin, June 24-25, 1983. Sponsored by the Family

Economics/Home Management Section of the American Home Economics Association; Kathryn D. Rettig and Mohamed Abdel-Ghany, editors and chairpersons. [Washington, DC] The Association, [c1986] 304 p.

Economic incentives for retirement in the public and private sectors. EBRI issue brief, no. 57, Aug. 1986: whole issue (15 p.)
"Indicates current legislative interest in increasing work among the elderly through changes in Social Security provisions and tax reform. The impact of the proposed abolition of mandatory retirement is also examined. Projections of labor force participation and compensation are reviewed to determine whether forecasting models anticipate any future changes in the pattern of retirement. Costs not incorporated in forecasting models that may influence employer-sponsored programs are also discussed, including greater-than-anticipated increases in longevity which could eventually lead to changes in pension plan provisions."

The Economics of aging: papers presented in a seminar series. Edited by Myron H. Ross. Sponsored by the Department of Economics at Western Michigan University. Kalamazoo, Mich., W. E. Upjohn Institute for Employment Research, 1985. 138 p.

Fox, Alan.
Earnings replacement rates and total income: findings from the retirement history study. Social security bulletin, v. 45, Oct. 1982: 3-22, 53.
"Describes and reports on the degree to which Social Security and private pensions replaced preretirement earnings for a sample of individuals retiring in the early 1970's."

Gustman, Alan L. Steinmeier, Thomas L.
A disaggregated, structural analysis of retirement by race, difficulty of work and health. Cambridge, Mass., National Bureau of Economic Research, 1985. 38, 21 p. (Working paper no. 1585)
Examines "differences in retirement rates between blacks and whites and between those in more and less physically demanding jobs, and uses maximum likelihood techniques to assess to what degree these differences are due to divergent market opportunities and to what degree they are due to divergent preferences among the groups."

Hamermesh, Daniel S.
Unemployment insurance and the older American. Kalamazoo, Mich., W. E. Upjohn Institute for Employment Research [1980] 117 p.
Contents.--UI and pensioners--provisions and problems.--Pensions and UI: effects on income distribution.--UI and consumption among older workers.--UI and retirement: work incentive or disincentive, windfall or discouragement.--The role of UI in the labor market for older workers: conclusions and suggested reforms.

Harrick, Edward J. Sultan, Paul E.
Workforce of the future: the problems and opportunities of maturity. Personnel, v. 59, July-Aug. 1982: 27-[illegible]
Long-range human resources planning calls for a look at three factors that will profoundly affect the composition of the workforce in the years ahead. The three factors--the demographics of the U.S. workforce, the economic status of the Federal social security system, and the employability of the older worker--are examined and their implications spelled out by the authors.

Iams, Howard M.
Employment of retired-worker women. Social security bulletin, v. 49, Mar. 1986: 5-13.
"Examines the employment rates of women about 18-30 months after they first received social security retired-worker benefits."

King, Gail Buchwalter. Stearns, Peter N.
The retirement experience as a policy factor: an applied history approach. Journal of social history, summer 1981: 589-625.
Traces retirement trends from the advent of modern retirement policy to the present time and examines the social and economic issues which have made it necessary to reevaluate the basic premises of retirement planning for the future. New factors to be considered include demographic changes, the financial burdens of pensions, the advent of the aged as a political force, and new insights on the relation of the elderly to employment.

[illegible]

Lawlor, Edward F.
The impact of age discrimination legislation on the labor force participation of aged men: a time-series analysis. Evaluation review, v. 10, Dec. [illegible]: [illegible].
"The 1978 amendments to the Age Discrimination in Employment Act (PL 95-256) outlawed mandatory retirement for most categories of workers between the ages of 65 and 70. This study examines labor force participation rates of men aged 65 years and over and fails to find any evidence that the amendments led to a change in their employment behavior."

[illegible], Nancy [illegible].
Influencing retirement behavior: a further analysis. Journal of policy analysis and management, v. [illegible], spring [illegible]: [illegible].
Concludes that "In evaluating proposals designed to stimulate the work effort of the elderly, policymakers must consider whether their goal is freedom of choice or maximum work effort. They must assess the effectiveness of the proposed change in light of both Social Security and private pensions. Finally, it is likely that any proposal will either inadvertently penalize some older people who are unhealthy, disabled, or unwillingly unemployed or inadvertently reward some older people whose work effort would have been at the maximum without the proposed change."

Meier, Elizabeth L. Dittmar, Cynthia C.
Variation of retirement ages. Rev. ed. [Washington], President's Commission on Pension Policy, for sale by the Supt. of Docs., G.P.O., [illegible]. [illegible] p.
At head of title: Working papers.
Partial contents.--Retirement trends.--Old-age normal and early retirement ages.--More early retirement.--Disability retirement ages.--Mandatory retirement and age discrimination legislation.--Retirement age and retirement costs.--Long-range aspects.

Retirement income goals, by Elizabeth L. Meier, Cynthia C. Dittmar, and Barbara Boyle Torrey. [Washington], President's Commission on Pension Policy, for sale by the Supt. of Docs., G.P.O., [illegible]. [illegible] p.
At head of title: Working papers.
Partial contents.--Relative and absolute measures of adequacy.--[illegible] retirement income goals.--Inflation and adequacy.--Summary of issues and options.

Mini-symposium on new roles for older workers: the employment options [illegible] managers' forum. Public administration review, v. [illegible], [illegible]: [illegible].
Contents.--[illegible] workforce: a strategic policy research agenda, by [illegible].--Expanding opportunities: strategies for increasing economic self-sufficiency of older Americans.--The National Association of Older Worker Employment Services: activities and policies.--[illegible] encouragement for using their skills.

Mitchell, Olivia S. Luzadis, Rebecca A.
[illegible] pension policy toward older workers. Cambridge, Mass., National Bureau of Economic Research, [illegible]. [illegible] p. (Working paper no. [illegible])
Develops "a new longitudinal data set on defined benefit pension plans covering the twenty-year period between 1960 and 1980, and indicate how and why employers' pension promises changed through time. Of special interest are private pension responses to exogenous changes including Social Security, income and payroll taxes, and the federal government's decision to lift the age at which mandatory retirement can be imposed."

Munnell, Alicia H.
ERISA--the first decade: was the legislation consistent with other national goals? Federal Reserve Bank of Boston New England economic review, Nov.-Dec. [illegible]: [illegible].
Examines the extent to which the provisions and implications of ERISA are consistent with other government policies--namely, federal tax provisions, employment policy, and retirement income objectives. This study reveals that, while most of ERISA's major provisions are consistent with these goals, some interesting anomalies do exist; for example, in the area of tax policy, ERISA failed to consider ways to ameliorate inequities created by the current integration guidelines or to improve alternatives to a totally employer-financed pension system.

Quinn, Joseph F.
The economic status of the elderly: beware of the mean. Review of income and wealth, no. 1, Mar. 1987: 63-82.

Warns that summary statistics about the elderly "may conceal more than they reveal. The diversity of the elderly is key . . . . Traditional Census data treat family size inadequately and exclude certain sources of income (such as in-kind benefits) that are important determinants of economic status."

Rappaport, Anna M.
Employee benefits, financial security and family structure in the post-Retirement Equity Act environment. Employee benefits journal, v. 10, June 1985: 9-16.

"Reviews the provisions of the Retirement Equity Act, the economic structures in different types of families and the situation with respect to various employee benefit situations under the Act. It will show that, overall, the Retirement Equity Act has done little to improve the situation and will offer some recommendations for changes in economic security arrangements which will help the situation."

Reno, Virginia P. Grad, Susan.
Economic security, 1935-85. Social security bulletin, v. 48, Dec. 1985: 5-20.

"Reviews broad economic changes over the past 50 years that are related to economic security for workers." Then, "the article focuses on the aged in general and on the newly retired in particular. It notes the dramatic change in economic well-being of the aged since the years just before benefits were first paid. It also documents the significant improvement in the economic status of new retirees from the early 1940's to the early 1980's."

Retirement income for an aging population; a report prepared by Congressional Research Service, Library of Congress, with analytic support from the Congressional Budget Office. Washington, G.P.O., 1987. 408 p.

At head of title: 100th Congress, 1st session, committee print WMCP: 100-22.

Contents.--Demography: the backdrop.--Preparing for the retirement of the baby boom: saving and investing.--Federal policies and roles in retirement income.--Influence of income on retirement patterns.--Building claims for retirement income.--Aging, health, and medical care.--Demographics and the aging population.--The dependency burden of an aging population: what measures do we have.--Preparing for the retirement of the baby boom: saving and investing.--Income, wealth, poverty and the life cycle.--Work, earnings and retirement.--Individual retirement saving and dissaving.--Social security.--Private pension plans.--Aging, health, and medical care.

Rix, Sara E.
Older Women: the economics of aging. Washington, Women's Research and Education Institute, Congressional Caucus for Women's Issues, 1984. 29 p.

Partial contents.--Income.--Labor force participation.

Robertson, Haeworth.
What is in the future for public retirement systems? [New York] William M. Mercer-Meidinger, 1986. 10 p.

"An address to the National Conference on Public Employee Retirement Systems in Boston on May 6, 1986."

Lists "a few facts and trends that may have a bearing on the future design and operation of public retirement systems--including Social Security, the largest public system of all. Then speculates about what effect those trends might have on public retirement systems."

Rosen, Benson. Jerdee, Thomas H.
Postponing retirement: can government and organizations make it attractive? Business horizons, v. 28, Nov.-Dec. 1985: 72-78.

Concludes that "given projected human resource shortages and economic strains on social security and pension programs, more emphasis is needed on identifying ways to encourage delayed retirement. Findings from the present study suggest that no single policy change will reverse the early-retirement trend dramatically. However, changes in governmental mandatory retirement and social security regulations, coupled with revisions in organizational career management programs, retirement policies, and pension regulations, could have substantial effects."

Retirement policies for the 21st century. Human resource management, v. 25, fall 1986: 405-420.
"Reports the views of a national sample of 897 executives on work and retirement. Identifies their reactions to pressures for early retirement, their responses to proposed incentives to delay retirement, and finally, their planned post retirement activities. Their responses have important implications for revising human resource policies in the years ahead."

Ross, Stanford G.
Private sector retirement security: the need for a comprehensive national income security policy. National journal, v. 16, Mar. 31, 1984: 640-645.
Former commissioner of social security aruges that "in undertaking to consider private sector retirement programs and tax policy affecting them, we must be cognizant of the larger problems that have been dramatically presented by the income security sector and the tax system. As we resolve these issues of what is an appropriate national standard for income security, and how to provide for it more efficiently and equitably, we may need to redesign private sector programs."

Rotherham, James A.
The railroad retirement program: a case study in the deficit dilemma. Public budgeting & finance, v. 5, autumn 1985: 40-57.
"The railroad retirement program currently pays about $5.9 billion annually in benefits to about 12 million annuitants and survivors. The program is one of the most complex entitlement programs operated by the federal government."
Notes past failures of efforts to impose benefit restraints on this program and concludes that such middle-class entitlements will make little contributions to resolving the Federal deficit.

Samuelson, Robert J.
Aging America--who will shoulder the growing burden? National journal, v. 10, Oct. 28, 1978: 1712-1717.
"How will the nation support its elderly? Social security, unless bolstered by substantial tax increases beyond those already scheduled, will not be able to bear the entire burden itself. Private pensions will help, but they, too, face substantial problems. Ultimately, the plight of the elderly will force some hard choices between individual and collective responsibility."

Schulz, James H.
To old folks with love: aged income maintenance in America. Gerontologist, v. 25, Oct. 1985: 464-471.
"Current policies concerning income in old age are framed in terms of important Social Security and private pension developments. Criticisms of the 'new Social Security' are viewed in the context of major problems associated with the options, especially private pensions."

Search for a national retirement income policy. Edited by Jack L. VanDerhei. Homewood, Ill., Published for the Pension Research Council, Wharton School, University of Pennsylvania by Irwin, 1987. 195 p.
"Papers presented at the 1985 Economic Security Symposium, cosponsored by the Pension Research Council and the Boettner Research Institute of the American College, held November 6-7, 1985, on the Bryn Mawr, Pennsylvania, campus of the college."

Smeeding, Timothy M.
Nonmoney income and the elderly: the case of the tweeners. Journal of policy analysis and management, v. 5, summer 1986: 707-724.
"Examines the degree of economic security experienced by the population aged 65 and over . . . . This analysis finds that elderly persons in the lower-middle income range--within 100 and 200 percent of the poverty line--are economically more vulnerable than either those of high income or those below the poverty threshold."

Social security and private pensions: our economic future. Contemporary policy issues, no. 3, Apr. 1983: whole issue.
Partial contents.--Social security: overview and options, by D. Worcester, Jr.--The significance and use of long-range actuarial cost estimates for the social security system, by R. Myers.--Employee benefits

and social security, by Y. Chen.--Providing income security to the elderly: the role of programs other than social security, by S. Schieber.--Public policy towards private pensions, by R. Ippolito.

Somers, Anne R.
Social, economic, and health aspects of mandatory retirement. Journal of health politics, policy and law, v. 6, fall 1981: 542-557.
Examines the major arguments for and against mandatory retirement. Suggests three principles in an effort to resolve the conflict: "the individual benefits more from activity--physical and mental--than inactivity; society benefits from the maximum feasible productive employment of the adult population; management requires adequate flexibility in the deployment of personnel, and a balance between youth and maturity and the values associated with each age group."

Soubel, Wendy G.
Situations and attitudes of retirees/older Americans. Brookfield, Wis., International Foundation of Employee Benefit Plans, c1984. 6 p. (Research report, 84-2)

SSA's retirement history study. Washington, U.S. Social Security Administration, Office of Policy, Office of Research and Statistics, 1987. 2 v. (398, 342 p.)
Contents.--Vol. 1. Compilation of reports.--Vol. 2. Technical description.
Collects reports from this landmark longitudinal study of aging and retirement done 1969 through 1979.

Storey, James R.
Emerging options for work and retirement policy (an analysis of major income and employment issues with an agenda for research priorities); an information paper prepared for use by the Special Committee on Aging, U.S. Senate. Washington, G.P.O., 1980. 186 p.
At head of title: 96th Congress, 2nd session. Committee print.

Study of total compensation in the Federal, State and private sectors. Prepared by Hay/Huggins Company and Hay Management Consultants for the Committee on Post Office and Civil Service, House of Representatives. Washington, G.P.O., 1984. 213 p.
At head of title: 98th Congress, 2nd session. Committee print 98-16.

Uhlenberg, Peter. Salmon, Mary Anne P.
Change in relative income of older women, 1960-1980. Gerontologist, v. 26, Apr. 1986: 164-170.
Finds that "the income distribution of cohorts entering old age more recently is well above that of the preceding cohorts, and there is some decline in inequality among older women over the past 20 years. The position of older women relative to middle-aged women, however, has not improved, and cohorts continue to experience large drops in income as they enter old age."

U.S. Congress. Conference Committees, 1986.
Federal Employees' Retirement System Act of 1986; conference report to accompany H.R. 2672. Washington, G.P.O., 1986. 160 p. (Report, Senate, 99th Congress, 2nd session, no. 99-302)

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Employment Opportunities.
The removal of age ceiling cap under the Age Discrimination in Employment Act. Joint hearing before the Subcommittee on Employment Opportunities of the Committee on Education and Labor and the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Mar. 12, 1986. Washington, G.P.O., 1986. 120 p.
"Subcommittee on Employment Opportunities--Serial no. 99-84"
"Subcommittee on Health and Long-Term Care--Serial no. 99-5601"

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Labor-Management Relations.
Oversight hearing on the Employee Retirement Income Security Act: requiring pension accruals for work beyond normal retirement age. Hearing, 98th Congress, 2nd session. Sept. 5, 1984. Washington, G.P.O., 1985. 144 p.

U.S. Congress. House. Committee on Post Office and Civil Service.
Implementation of Federal Employees' Retirement System. Hearings, 100th Congress, 1st session. Mar. 24-25, 1987. Washington, G.P.O., 1987. 142 p.
"Serial no. 100-12"

U.S. Congress. House. Select Committee on Aging.
Abolishing poverty along older Americans. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 72 p.
Hearing held July 18, 1987, Boston, MA.
"Comm. pub. no. 100-6371"

The economics of aging: a need for pre-retirement planning. Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 104 p.
"Comm. pub. no. 98-422"
Hearing held in Jefferson City and Clinton, Mo., Sept. 16, 1983.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Eliminating mandatory retirement; a report. Washington, G.P.O., 1986. 13 p.
At head of title: Committee print.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment.
Public policy and the future of work and retirement. Joint hearing before the Subcommittee on Retirement Income and Employment and the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, Ninety-fifth Congress, second session. May 3, 1978. Washington, G.P.O., 1978. 134 p.
"Comm. pub. 95-143"

U.S. Congress. Senate. Committee on Governmental Affairs. Subcommittee on Civil Service, Post Office, and General Services.
Forums on Federal pensions. Washington, G.P.O., 1985. 109 p. (Print, Senate, 98th Congress, 2nd session, committee print S. Prt. 98-159, part 3)
Part 3--Employer retirement programs and social security.

U.S. Congress. Senate. Special Committee on Aging.
Working Americans: equality at any age. Hearing, 99th Congress, 2nd session. June 19, 1986. Washington, G.P.O., 1986. 160 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-826)
"Serial no. 99-21"

U.S. Federal Council on Aging.
Toward a national older worker policy; an information paper for use by the Special Committee on Aging. Washington, G.P.O., 1981. 62 p.
At head of title: 97th Congress, 1st session. Committee print.

U.S. General Accounting Office.
Benefit levels of nonfederal retirement programs; report. Feb. 26, 1985. Washington, G.A.O., 1985. 28 p.
"GAO/GGD-85-30"
"Estimates the levels of benefits available from nonfederal retirement programs using selected studies and data bases. Social security, pension plan, and capital accumulation plan benefits are shown for different categories of age and years of service and at varying final salary levels."

Features of nonfederal retirement programs; report. June 26, 1984. Washington, G.A.O., 1984. 28 p.
"GAO/OCG-84-2"

Railroad retirement: size, nature, and funding sources; fact sheet for the Chairman, Committee on the Budget, U.S. Senate. Mar. 1986. Washington, G.A.O., 1986. 17 p.
"GAO/HRD-86-73FS"
Reports on Federal financial involvement in the railroad retirement program.

Retirement before age 65: trends, costs, and national issues; report to the Chairman, Select Committee on Aging, House of Representatives. July 1986. Washington, G.A.O., 1986. 73 p.

"GAO/HRD-86-86"

"Documents the trend toward earlier receipt of employer-sponsored pensions, shows that most pension recipients do not take other jobs, and estimates both Social Security and income tax revenue losses due to voluntary early retirement."

U.S. President's Commission on Pension Policy.

Coming of age: toward a national retirement income policy. Washington, 1981. 131 p.

"This report calls for a long-term shifting of dependency on pay-as-you-go financed federal programs such as social security, welfare and in-kind benefit programs to a balanced program of employee pensions, social security and individual effort."

Ycas, Martynas A. Grad, Susan.

Income of retirement-aged persons in the United States. Social security bulletin, v. 50, July 1987: 5-14.

"Changes in the composition of income of the aged over the past 20-30 years, including greatly expanded Social Security and pension coverage and an increasing number of persons with retirement savings, have improved the economic status of the aged not only in comparison with the aged in earlier years, but also in comparison with younger adults who derive most of their income from earnings."

ELIGIBILITY FOR FEDERAL ENTITLEMENT PROGRAMS

Ball, Robert M.

Income security for the elderly. National journal, v. 10, Oct. 28, 1978: 1748-1753.

Analyzes the four levels of income security for the elderly--universal, contributory, wage-related social insurance; private pension systems; individual savings; and means-tested programs designed to provide minimum income to those who are eligible.

Bayer, Ronald. Callahan, Daniel.

Medicare reform: social and ethical perspective. Journal of health politics, policy and law, v. 10, fall 1985: 533-547.

"Examines the validity of the ultimate moral and social rationales for continuing Medicare in something approximating its present form; the legitimacy of a social entitlement program that is age- rather than means-based; the implications for the future of health care reform if significant changes were to be made in the Medicare program and its underlying rationale; and the possibility that changes in that program may jeopardize the chances for a more rational, just, and systematic approach to the provision of health care to all Americans."

Chambers, Donald E.

Policy weaknesses and political opportunities. Social service review, v. 59, Mar. 1985: 1-17.

Examines "three particular ways in which the Reagan administration has successfully exploited some revealing weaknesses in eligibility definitions and accountability features of SSDI Social Security Disability Insurance and SSI Supplemental Security Income policy: various extensions and reinterpretations of the definition of disability, some political intrusions into the SSDI/SSI 'fair-hearing' process, and the Social Security Administration's (SSA) policy of administrative 'nonacquiescence' to Federal court rulings with which SSA disagrees."

Cunningham, Robert M., Jr.

Social security must change: means test hard but necessary. Hospitals, v. 56, Dec. 16, 1982: 87-88, 90.

"Applying a means test to social security benefits is a possibility that won't disappear in an increasing aged population. Without a way to evaluate eligibility, social security funds may diminish for the truly needy."

Entitlement issues in the domestic budget: the long-term agenda. Edited by John C. Weicher. Washington, American Enterprise Institute for Public Policy Research, 1985. 52 p. (AEI symposia 85B)
Partial contents.--Social security: financing rising benefits and other issues, by Mickey D. Levy.--Major issues in Medicare, by Jack A. Meyer.--Civil Service pay and retirement, by Annelise Graebner Anderson.

Fallows, James.
Entitlements. Atlantic monthly, v. 250, Nov. 1982: 51-59.
Analyzes the reasons for the growth in the retirement entitlement programs, such as social security, civil service retirement, and military pensions.

Financing work-related entitlement programs; a report prepared by the Congressional Research Service for the Committee on the Budget, United States Senate. Washington, G.P.O., 1983. 534 p. (Print, Senate, 98th Congress, 1st session, committee print S. Prt. 98-48)

Financing work-related entitlement programs: an update; report prepared by the Congressional Research Service for the Committee on the Budget, U.S. Senate. Washigngton, G.P.O., 1985. 126 p. (Print, Senate, 98th Congress, 2nd session, committee print S. Prt. 98-283)

Haas, Lawrence J.
Big-ticket restrictions. National journal, v. 19, Sept. 26, 1987: 2413-2416, 2418.
"Social security and medicare, the two largest entitlement programs, may be subjected to new cost-control strategies as Congress struggles with budget deficits."

Hardin, Clifford M. Chilton, Kenneth W.
Budget control and indexed entitlements: are they compatible? St. Louis, Center for the Study of American Business, Washington University, 1981. 31 p. (Center for the Study of American Business. Publication no. 40)

Hatten, James.
Medicare's common denominator: the covered population. Health care financing review, v. 2, fall 1980: 53-64.
"Describes Medicare eligibility requirements; the processes to establish Medicare entitlement; types of coverage; the composition of the enrolled population; and outlines some differences in measurement techniques used in a decennial census in contrast to Medicare enrollment."

Hubbard, R. Glenn.
Social security and household portfolio allocation. Cambridge, Mass., National Bureau of Economic Research, 1984. 35 p. (Working paper no. 1361)
"The entitlement to social security retirement benefits is a major component of aggregate household wealth. This paper focuses on the impact of social security annuities on household portfolio allocation, extending existing optimizing models of portfolio allocation to explicitly consider the role of social security."

Kahn, Arthur L.
Program and demographic characteristics of supplemental security income recipients, December 1985. Social security bulletin, v. 50, May 1987: 23-57.
Focuses on recipients of the Federal program for the nation's needy "who, in addition to being poor, were also aged, blind, or disabled." Charts "reasons for eligibility, payment distribution, sex, age, race, income, resources, living arrangements, and metropolitan residency. Provisions of the federally administered program, including the basic eligibility requirements--updated through January 1987--are also presented."

Kaufmann, Franz-Xaver. Leisering, Lutz.
Demographic changes as a problem for social security systems. International social security review, v. 37, Apr. 1984: 388-409.
Contends that "to the extent that social security systems cover practically the entire population and that eligibility is linked to a specific age, it is obvious that demographic changes having an impact on the relative sizes of the age groups inevitably have an impact on the budgets of the social security systems."

Lingg, Barbara A.
Beneficiaries affected by the annual earnings test in 1982. Social security bulletin, v. 49, May 1986: 25-32.
"Presents detailed statistical data about persons affected by the earnings test in 1982. Most of the data are for retired-worker beneficiaries. Limited data on dependent and survivor beneficiaries who are subject to a test of 'substantial gainful activity,' and persons residing in foreign countries, who are subject to a different earnings test."

Martin, Peter W.
Public assurance of an adequate minimum income in old age: the erratic partnership between social insurance and public assistance. Cornell law review, v. 64, Mar. 1979: 437-520.
Article traces the interaction between "social insurance" and "public assistance" benefits for the elderly.

Rogers, Gayle Thompson.
Aged widows and OASDI: age at and economic status before and after receipt of benefits. Social security bulletin, v. 44, Mar. 1981: 3-19.
"Describes the income, labor-force, and demographic characteristics of widows 2 to 3 years before they become eligible for old-age benefits under the old-age, survivors, and disability insurance (OASDI) program; examines the age at which they elect benefits and the characteristics associated with that decision; and compares their economic status before and after they begin collecting benefits."

Rotherham, James A.
The railroad retirement program: a case study in the deficit dilemma. Public budgeting & finance, v. 5, autumn 1985: 40-57.
"The railroad retirement program currently pays about $5.9 billion annually in benefits to about 12 million annuitants and survivors. The program is one of the most complex entitlement programs operated by the federal government."
Notes past failures of efforts to impose benefit restraints on this program and concludes that such middle-class entitlements will make little contributions to resolving the Federal deficit.

Taming the Federal budget: fiscal year 1986, a report. Edited by Stuart M. Butler. Washington, Heritage Foundation, 1985. 51 p.
Partial contents.--Time for a new strategy to cut the budget, by S. Butler.--Reevaluating entitlement strategy, by S. Kondratas.

U.S. Congress. House. Committee on Aging. Subcommittee on Retirement Income and Employment.
Social security: a critique of recommendations to tax benefits and to raise the eligibility age for retirement benefits; a report with additional views by the Subcommittee on Retirement Income and Employment of the Select Committee on Aging, House of Representatives, 96th Congress, 2d session. Washington, G.P.O., 1980. 39 p.
At head of title: Committee print.
"Comm. pub. no. 96-235"

U.S. Congress. House. Committee on the Budget.
Impact of budget proposals on health entitlement programs, Medicare. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1985. 363 p.
"Serial no. 99-3"
Hearing held Feb. 13, 1985, Irving, Tex.

U.S. Congress. House. Committee on the Budget. Task Force on Entitlements, Uncontrollables, and Indexing.
Non-means-tested entitlement reform programs. Hearing, 98th Congress, 1st session. Mar. 1, 1983. Washington, G.P.O., 1983. 155 p.
"Serial no. TF8-2"

Options for changing indexation of entitlement programs. Hearing, 98th Congress, 1st session. Nov. 9, 1983. Washington, G.P.O., 1983. 197 p.
"Serial no. TF8-10"

Report of President's Private Sector Survey on Cost Control. Hearing, 98th Congress, 1st session. Nov. 2, 1983. Washington, G.P.O., 1984. 78 p.
"Serial no. TG8-9"

Inquires into the Grace Commission's studies and recommendations on entitlement programs, specifically civil service and military retirement, Medicare and Medicaid, and food stamps.

U.S. Congress. House. Committee on the Budget. Task Force on Income Security.
Budgetary review of income security programs. Hearings, 100th Congress, 1st session. Nov. 9 and 10, 1987. Washington, G.P.O., 1987. 387 p.
"Serial no. 8-1"

U.S. Congressional Budget Office.
Interactions among programs providing benefits to individuals: secondary effects on the budget. Washington, [1982] 56 p.
"Reductions in programs that provide benefits to individuals often produce large offsetting increases and decreases in spending by other programs. These offsets have important, differential effects on federal and state budgets as well as on the individuals affected. This report . . . estimates these interaction effects for two general options to achieve spending reductions: an across-the-board benefit reduction and an eligibility restriction."

U.S. General Accounting Office.
Federal benefit programs: a profile. Oct. 17, 1985. Washington, G.A.O., 1985. 102 p.
"GAO/HRD 86-14"
"Profiles 150 federal benefit programs that provide cash or noncash assistance to persons demonstrating need or who qualify for benefits as a result of either (1) contributions made by them or on their behalf or (2) military service." Also, "for 91 selected programs this document (1) provides financial and other related data; (2) describes their purposes, who is eligible for them, and the benefits available; and (3) identifies the federal agencies that administer them and the congressional committees that oversee them."

Railroad retirement program--how does it compare to other selected retirement programs? report. [Washington] 1979. 53 p.
"HRD-79-41, June 8, 1979"
"This report compares the railroad retirement program with those of social security, civil service retirement, military retirement, and veterans pension. While they all provide family maintenance income, they vary widely in size, scope, eligibility requirements, benefits, employment and income restrictions, and employee contribution."

Wing, Kenneth R.
Medicare and President Reagan's second term. American journal of public health, v. 75, July 1985: 782-784.
"One of the major objectives of the Reagan Administration during its second term in office is a major assault on federal support for the Medicare program as well as other federally sponsored social welfare entitlement programs. Medicare in particular will be singled out for severe budgetary limits; but the real public policy question may well be whether the Administration can successfully convince Congress to recast the program as something less than a statutory entitlement."

SOCIAL SECURITY

Achenbaum, W. Andrew.
Social security: visions and revisions. Cambridge [Cambridgeshire] Cambridge University Press, 1986. 300 p.
"A Twentieth Century Fund study."

American Institute of Certified Public Accountants. Federal Tax Division.
Suggested improvements for the Social Security retirement system. Issued by the Federal Tax Division of the American Institute of Certified Public Accountants. New York, AICPA, c1987. 67 p. (Statement of tax policy; 8)

Anderson, Harry, and others.
The social-security crisis. Newsweek, v. 101, Jan. 24, 1983: 18-23, 25-26, 28.
Describes some of the proposed recommendations of the National Commission on Social Security Reform that would help to "shore up" the finances of the system. Looks at what Congress might do with these recommendations.

Andrews, George H. Beckman, John A.
Actuarial projections for the old-age survivors, and disability insurance program of social security in the United States of America. Itasca, Ill., Actuarial Education and Research Fund, c1987. 188 p.

Annotated readings in social security. Washington, U.S. Social Security Administration, for sale by the Supt. of Docs., G.P.O., 1982. 600 p. (SSA publication no. 13-11754)
Contents.--Background & general issues.--Retirement & survivors insurance.--Disability insurance.--Health insurance.--Public assistance & public welfare.--Other income-maintenance programs.--International issues & studies.--Research methodology.--Statistical publications.--Management & administration.--Legislation.--Reference materials.

Auerbach, Alan J. Kotlikoff, Laurence J.
Simulating alternative social security responses to the demographic transition. National tax journal, v. 37, June 1985: 153-168.
Predicts a long-run decline in the dependency ratio, with the reduction in dependent children per worker more than offsetting the increase in retirees per worker."

Ballantyne, Harry C.
Present policies and methods regarding the long-term adjustment of benefits. Social security bulletin, v. 47, Oct. 1984: 9-12.
"If beneficiaries are to maintain their standard of living at a level close to what it was before they left the workforce, the payments they receive under the Social Security program must be periodically adjusted to account for changes in the cost of living. This article describes the policies and practices employed by the Social Security Administration to accomplish this objective."

Barron, Erma W.
The role of research and statistics in the development of social security. Social security bulletin, v. 48, Nov. 1985: 5-22.
"Examines the part played by research and statistics in the development of the Federal old-age benefit program into what is commonly referred to now as social security--the old-age, survivors, and disability insurance (OASDI) program. It provides a historical overview of research activities relevant to major OASDI program developments over the past 50 years."

Baum, Sandra R. Sjogren, Jane.
Alternative social security indexing schemes and poverty among the elderly. Policy studies journal, v. 12, Sept. 1983: 79-90.
"Conclude that proposed minor modifications in the indexing scheme for Social Security benefits would not have a large impact on the distribution of income among recipients . . . . Even a small decline in the rate of indexing would have a substantial impact on official poverty rates among the elderly. A tradeoff clearly exists between reducing the growth of the Social Security system's expenditures by slowing benefit increases and the extent of poverty among the elderly."

Bell, Donald. Hill, Diane.
How social security payments affect private pensions. Monthly labor review, v. 107, May 1984: 15-20.
"Coordinating the two sources of retirement income tends to lower employer costs for private pension plans, and results in private pensions which replace a larger percentage of preretirement earnings for higher paid workers."

Bernheim, B. Douglas.
Social security benefits: an empirical study of expectations and realizations. Cambridge, Mass., National Bureau of Economic Research, 1987. 47 p. (Working paper no. 2257)
Studied "the accuracy of pre-retirement expectations concerning social security benefits." Among the conclusions were that "consumers do not form expectations on the basis of all available information" and that

"individuals do not ignore or forget information which they have used in the past, and they tend to form all expectations on the basis of the same information."

Berry, John M.
Assumption of huge surpluses flaws social-security solution. Financier, v. 7, May 1983: 12-15.
"Enormous surpluses projected in the Social Security rescue legislation recently enacted will be bookkeeping entries in the Unified Budget at best, and may not materialize at all. Consequently, while the new legislation has created a short-term solution to the immediate and serious Social Security problem, it has left unresolved equally serious problems that will threaten the system before the end of the century, and may have created some new ones."

Birdsall, William C. Hankins, John L.
The future of social security. In The welfare state in America: trends and prospects. Beverly Hills, Calif., Sage Publications, 1985. (Annals of the American Academy of Political and Social Science, v. 479, May 1985). p. 119-131.
"How well social security has done, is doing, and is projected to do are analyzed in terms of the system's twin goals of adequacy and individual equity. Contends that options for change are severely limited by our stumbling economy and the high costs of a mature pension system. It is not likely that the traditional groups and alliances that played important roles in the expansion of social security will play predictable roles in its retrenchment."

Boaz, Rachel Floersheim.
The 1983 Amendments to the Social Security Act: will they delay retirement? A summary of the evidence. Gerontologist, v. 27, Apr. 1987: 151-155.
"The 1983 Amendments to the Social Security Act are designed to attain simultaneously two long-term goals of public policy: to restrain the growth in Social Security expenditures by reducing the amount of lifetime benefits to be paid to future beneficiaries and to encourage continued work by removing the work disincentives generated by the Social Security system. Although the reduction in benefits is certain, continued work is not very likely. Hence, legislated reductions in lifetime benefits may cause financial hardship for beneficiaries who depend on Social Security benefits for income support."

Boskin, Michael J.
Future social security financing alternatives and national saving. Cambridge, Mass., National Bureau of Economic Research, 1987. 30, 27 p. (Working paper no. 2256)
"OASDI is projected to accrue a very large surplus over the next thirty years, peaking at almost 30% of GNP . . . . These alternatives may affect net national saving, directly because Social Security surpluses or deficits are part of government sector saving and indirectly through effects on private saving or the non-Social Security part of the federal government budget. This paper documents how various systematic deviations from, or return to, pay-as-you-go finance of the Social Security system may affect net national saving."

Social security: a financial appraisal across and within generations. Cambridge, Mass., National Bureau of Economic Research, 1986. 37 p. (Working paper no. 1891)
"Computes the expected present value of Social Security retirement benefits and taxes for households of different marital circumstances, incomes, and age cohorts. Also computed are the net gain or loss from participation in the system and the expected internal rate of return it offers various participants . . . . The general results are made for the 1985 Social Security and income tax laws."

Too many promises: the uncertain future of social security. Homewood, Ill., Dow Jones-Irwin, c1986. 196 p.
"A Twentieth Century Fund report."

Indexing social security benefits: a separate price index for the elderly?, by Michael J. Boskin and Michael D. Hurd. Public finance quarterly, v. 13, Oct. 1985: 436-449.

"Focuses on the issue of the extent to which the cost of living actually differed for the elderly relative to the general population in the inflationary binge of the last 20 years . . . . Concludes that (conditional on an adjustment for the inappropriate treatment of housing in the CPI) the inflation experience of the elderly from 1961 to 1981 was similar to that of the general population, both cumulatively and year by year."

The financial impact of social security by cohort under alternative financing assumptions, by Michael J. Boskin and Douglas J. Puffert. Cambridge, Mass., National Bureau of Economic Research, 1987. 28, 23 p. (Working paper no. 2225)

"Analyses the financial impact of Social Security by age cohort under alternative assumptions concerning future financing of Social Security . . . . Importantly, it examines the implications of alternative potential resolutions of the long-term financing deficit and scenarios concerning the planned systematic deviation from pay-as-you-go finance in the retirement and disability funds."

Social security and the American family. Cambridge, Mass., National Bureau of Economic Research, 1987. 35 p. (NBER working paper no. 2117)

"Presents the results of a computer simulation of the expected present value of benefits, taxes, and transfers, rates of return, and marginal linkage of benefits and taxes for persons of different income levels and family status."

Bould, Sally.
Factors influencing the choice of social security early retirement benefits. Population research and policy review, v. 5, no. 3, 1986: 217-235.

"Focuses directly on the choice of early retirement Social Security benefits in 1973 for men who responded to the National Retirement History Survey." Warns that "the option of eliminating or reducing early retirement benefits would have severe consequences in terms of poverty created. Furthermore, it may not have the cost savings projected since costs would be passed on to other programs or reallocated within Social Security."

Bristol, James T.
Integrating pension plans with social security. Arkansas business and economic review, v. 18, no. 3, 1985: 6-14.

Discusses "integration procedures for defined contribution and defined benefit pension plans. With judicious planning and foresight, the employer may integrate a pension plan with SS benefits to ensure that all retirees receive approximately the same wage replacement ratio."

Burtless, Gary.
Social security, unanticipated benefit increases, and the timing of retirement. Review of economic studies, v. 53, Oct. 1986: 781-805.

"Between 1969 and 1972, real U.S. social retirement benefits rose by 20%. . . . This paper proposes a model of retirement behaviour in which workers respond differently, although in a theoretically consistent manner, to the anticipated and unanticipated components of the social security benefit they can receive upon retirement. The retirement age decision in the presence of unanticipated benefit changes is shown to be a special case of utility maximization under a nonlinear budget constraint."

Social security, earnings tests, and age at retirement, by Gary Burtless and Robert A. Moffitt. Public finance quarterly, v. 14, Jan. 1986: 3-27.

Analyzes the effect of social security on retirement decisions. "The article shows the labor-supply effect of actuarial unfairness in the benefit formula, the impact of an earnings test in causing workers to postpone retirement (thus increasing lifetime labor supply), and the impact of imperfect capital markets on the timing of retirement."

A Challenge to social security: the changing roles of women and men in American society. Edited by Richard V. Burkhauser and Karen C. Holden. New York, Academic Press, c1982. 272 p. (Institute for Research on Poverty monograph series)

Checks and balances in social security: symposium in honor of Robert J. Myers. Symposium convened and directed by Yung-Ping Chen. Edited by Yung-Ping Chen and George F. Rohrlich. Lanham, MD, University Press of America, c1986. 357 p.

Cobb, Jean. Montgomery, Peter.
Social security: is it ripe for reform? Common cause magazine, v. 14, Jan./Feb. 1988: 31-33.

Committee for Economic Development. Program Committee.
Social security, from crisis to crisis?: a statement by the Program Committee of the Committee for Economic Development. New York, CED, [1984] 22 p.

Compilation for the social security laws including the Social Security Act, as amended, and related enactments through January 1, 1987. Washington, G.P.O., 1987. 2 v. (1080, 954 p.)
At head of title: 100th Congress, 1st session, committee print, WMCP: 100-14 (vol. 1); 100-15 (vol. 2)
"Compiled by the Social Security Administration, [and] Department of Health and Human Services;" Printed for the use of the House Committee on Ways and Means.

Constraining social security cost-of-living adjustments: background and issues; a report prepared by the Congressional Research Service for the Committee on the Budget, U.S. Senate. Washington, G.P.O., 1985. 31 p. (Print, Senate, 99th Congress, 1st session, committee print S. Prt. 99-2)

Controlling the cost of social security. Edited by Colin D. Campbell. Lexington, Mass, Lexington Books, c1984. 269 p.
Papers originally presented at a conference sponsored by the American Enterprise Institute for Public Policy Research in Washington, D.C., June 25-26, 1981. "An American Enterprise Institute book."

Controversy over social security reform proposals. Congressional digest, v. 62, Apr. 1983: 97-128.
Includes pro statements by the National Association of Manufacturers, the United Auto Workers, and the Save Our Security Coalition. Con statements were written by the American Farm Bureau Federation, the American Association of Retired Persons and the National Association of Letter Carriers.

Crank, Sandy.
The evolution of privacy and disclosure policy in the Social Security Administration. Social security bulletin, v. 48, June 1985: 7-13.
"Describes, from a historical perspective, the efforts of the Social Security Administration (SSA) to protect the confidentiality of personal information in its records. Significant changes in disclosure policy are cataloged and elements of the policy are outlined."

Cronin, Michael A.
Fifty years of operations in the Social Security Administration. Social security bulletin, v. 48, June 1985: 14-26.
"Traces 50 years of developments in two of the Social Security Administration's (SSA's) most significant operations--social security number issuance and wage recording--and in the agency's network of field offices, with special emphasis on the years immediately following passage of the Social Security Act of 1935."

Democratic Study Group.
The new social security law. Washington, The Group, 1983. 26 p. (DSG fact sheet no. 98-5)
"Deals with the conference agreement on H.R 1900, Social Security Act Amendments of 1983, which was adopted by both Houses on March 24 . . . . The legislation makes numerous changes in the Social Security system in order to solve the system's financial problems. The measure also extends supplemental unemployment benefits and makes changes in the way hospitals are reimbursed for treating Medicare patients."

Duleep, Harriet.
Implications for social security policy-making of research in mortality. International social security review, v. 37, Apr. 1984: 410-423.
"Outlines the relationship between mortality research and policy-making in social security. Gives reasons as to why more information is needed

for social security purposes on how and why mortality varies over time periods and across population groups; a synopsis of the correspondence between the type of policy question asked and the kind of research required to answer it; and discusses the incorporation of mortality research into policy models."

Earnings sharing options for the social security system. Washington, Congressional Budget Office, 1986. 177 p.
"A number of proposals have been made that would combine the earnings of husbands and wives and divide them equally for the purpose of calculating Social Security benefits--'earnings sharing'." Examines the potential of a couple of earnings sharing plans as well as options for making the transition to these plans.

Feldstein, Martin.
Should social security benefits be means tested? Journal of political economy, v. 95, June 1987: 468-484.
"Social security retirement benefits distort the saving decisions of workers who are rational enough to save for their future . . . . The present paper examines the conditions under which the welfare loss could be reduced by replacing the current universal social security program with a means-tested program that pays benefits only to those individuals with little or no other retirement income or assets."
Updates the author's National Bureau of Economic Research's 1985 working paper no. 1775.

Should social security benefits increase with age? Cambridge, Mass., Harvard Institute of Economic Research, 1987. 16 p. (Discussion paper no. 1313)
"Shows that the optimal relations between social security benefits and retiree age depends on balancing the advantage of providing an otherwise unavailable actuarially fair annuity against the lower rate of return earned in a pay-as-you-go social security system."
Also published as the National Bureau of Economic Research, NBER working paper no. 2200.

Ferrara, Peter J.
For social security, the crisis continues. Washington, Heritage Foundation, 1985. 16 p. (Backgrounder no. 467)
Contends that "Social Security was not rescued in 1983 and that the system is still sailing on a crash course toward a financial iceberg."

A winning way to trim social security by switching to "super IRAs." Fortune, v. 113, Jan. 6, 1986: 113-114.
Says there is a way to slash the future costs of social security that may be politically feasible if Congress passes legislation to allow workers the option of substituting expanded IRAs ("Super Iras") for part of their social security security coverage.

Fields, Gary S. Mitchell, Olivia S.
The effects of social security reforms on retirement ages and retirement incomes. *Journal of public economics*, v. 25, Nov. 1984: 143-159.
"Four specific changes in the structure of Social Security benefits are examined: raising the normal retirement age, delaying the cost-of-living adjustment, lowering early retirement benefits, and increasing late retirement payments . . . . Predicted changes in retirement ages will be too small to compensate retirees for reductions in benefit formulas. Thus, the Social Security's financial burden will be eased, but retirees' incomes will fall on average."

The effects of social security reforms on retirement ages and retirement incomes. Cambridge, Mass., National Bureau of Economic Research, 1984. 26 p. (Working paper no. 1348)

Fifty years of social security: past achievements and future challenges: an information paper prepared for use by the Special Committee on Aging, United States Senate. Washington, G.P.O., 1985. 87 p. (Print, Senate, 99th Congress, 1st session, committee print S. Prt. 99-75)
Compilation of papers commissioned by Carnegie-Mellon University "for release at a special conference and committee briefing held on the campus of CMU, on August 13, 1985."

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"Calculates the present value of lifetime contributions to the Social Security system of a sample of the elderly, and the present value of their expected benefits . . . . Also computes for each family in our sample the internal rate of return to the retirement program."

Irick, Christine.
Income of new retired workers by social security benefit levels: findings from the new beneficiary survey. Social security bulletin, v. 48, May 1985: 7-23.
"Examines the extent to which recent retirees with relatively low or high-earnings-related social security benefits do, in fact, have other income. It also examines how total income from all sources varies by the level of earnings-related benefits from the social security program."

Jehle, Faustin F.
The complete & easy guide to Social Security & Medicare. Madison, Conn., Fraser Pub. Co.; Charlotte, VT, Distribution by Williamson Pub. Co, c1986. 178 p.

Johnson, Barbara Brooks.
The changing role of women and social security reform. Social work, v. 32, July-Aug. 1987: 341-343.
"As increasing numbers of working-age women enter the paid labor force, women's groups are voicing their concerns of the inequitable distribution of Social Security benefits. The author reviews those concerns, discusses three options for reform of the program, and informs women of the changes in the program they can expect realistically."

Kasten, Richard A. Smith, Ralph.
Effects on family incomes of one option for reducing COLAs for non-means-tested program benefits and increasing SSI benefits. Washington, U.S. Congressional Budget Office, 1985. 8 p.
"Analyzes the effects on family incomes of altering the cost-of-living adjustments (COLAs) scheduled to be given to recipients of Social Security and other non-means-tested cash transfer program benefits in 1986, 1987, and 1988, and increasing Federal Supplemental Security Income (SSI) guarantee levels by $10 per month for individuals and $15 per month for couples."

Kingson, Eric R.
Financing social security: agenda-setting and the enactment of the 1983 amendments to the Social Security Act. Policy studies journal, v. 13, Sept. 1984: 131-155.
"Discusses the enactment of the 1983 Amendments to the Social Security Act as the outcome of a two stage agenda-building process . . . . Reviews economic and political factors that acted in concert to move financing problems to the top of the Social Security agenda, thereby setting the stage for the 1983 Amendments. This paper also speculates on why specific proposals (e.g., partial taxation of benefits, small increases in payroll taxation) emerge as public policy."

What you must know about social security & medicare. New York, Pharos Books, distributed in the U.S. by Ballantine Books, 1987. 128 p.

Kirkland, Kenneth J.
Social security reform: how will it affect the states? State legislatures, v. 9, Apr. 1983: 6-9.
"The Commission on Social Security Reform fashioned an impressive compromise that masterfully earned congressional approval. But the plan does raise troublesome issues, including its potential effect on the states."

Koitz, David.
Social security: favorable projections raise fiscal policy questions. Congressional Research Service review, v. 7, July-Aug. 1986: 12-13, 25-28.
"The financial condition of the social security programs of Old Age, Survivors, and Disability Insurance (OASDI) has improved steadily since Congress enacted major changes to them in 1983. In their latest report, the social security trustees project that favorable conditions will continue for many years. Under their Intermediate II-B forecast--the one cited most often in their reports--excess income would be posted to the social security trust funds until around the year 2030. Deficits would

follow, but the buildup of Federal securities in the trust funds arising from the earlier excess income presumably would be sufficient to keep the trust funds solvent until 2051."

Kutza, Elizabeth Ann.
The promise of certainty. Social service review, v. 60, Mar. 1986: 132-144.
Examines whether advice received by Congress on the management of the social security system is acted on "and how much of the system's current uncertainty rests not with the economic or social environment or with the program's overseers but with the behavior of individuals who respond to a political environment."

Lampman, Robert J.
Balancing the books: social spending and the American economy. Washington, National Conference on Social Welfare, c1985. 79 p.

Lazear, Edward P.
Social security and pensions. Cambridge, Mass., National Bureau of Economic Research, 1984. 47 p. (Working paper no. 1322)
"Recent and proposed changes in the social security statutes can have profound effects on worker behavior and on pensions themselves. In the context of an optimal lifetime compensation plan, pensions depend on efficient dates of retirement. To the extent that changes in social security affect the efficient date of retirement, both the pension and the wage profile itself will react. Four proposed changes in the social security system are analyzed. The cost savings associated with the change, as well as the effect on pensions and worker compensation in general are discussed."

Lee, Robert W.
Social security: the phony insurance policy you wouldn't buy. American opinion, v. 26, Jan. 1983: 13-14, 17-18, 89, 91-96, 98.
"Secure retirement for our elderly is in danger as the Social Security program teeters on the verge of bankruptcy. As things stand the government must find an additional $14 billion just to keep the system afloat through 1985, and a total of $200 billion will be required to stave off collapse until the end of this decade . . . . A number of viable options has been offered to make Social Security a privately operated retirement program."

Leff, Mark H.
Taxing the "forgotten man": the politics of social security finance in the New Deal. Journal of American history, v. 70, Sept. 1983: 359-381.
Analyzes why the New Deal decided to rely "exclusively on regressive payroll taxes to finance old-age annuities."

Leiby, James.
Social security at 50. Public welfare, v. 43, fall 1985: 4-11.
Concludes that "the fiftieth anniversary of the Social Security Act may remind us that the problems of the relation of public assistance and social insurance to general social and economic reform, to unemployment, to services, and to community organization and development are recurring problems; if anything, the problems may be more clearly defined now, because of our experience, and we have more resources and a better understanding of their possibilities and limits than people had in 1935."

Lesnoy, Selig D. Leimer, Dean R.
Social security and private saving: theory and historical evidence. Social security bulletin, v. 48, Jan. 1985: 14-30.
Assesses the continuing debate over Martin Feldstein's research and more recent evidence concerning the relationship between social security and the economy. Finds that "the historical evidence fails to support the hypothesis that social security has reduced private saving."

Levy, Mickey D.
Social security: financing rising benefits and other issues. In Entitlement issues in the domestic budget: the long-term agenda; a conference sponsored by the American Enterprise Institute for Public Policy Research. Edited by John C. Weicher. Washington, The Institute, c1985. (AEI symposia 83B). p. 4-14.
"Argues that the unfinished legislative agenda for social security is lengthy and that now is the proper time to take steps toward improving some of the system's flaws."

Light, Paul.
Artful work: the politics of social security reform. New York, Random House, 1985. 255 p. (Random House series in political science)
Examines the 1983 "rescue" of social security and its lessons for the budget and Medicare crises. This book "looks at how President Reagan tried and failed to set the social security agenda, and how a small band of social security lenders set the deadline for him. It offers the first details on the secret meetings that produced a final social security package, and asks why the National Commission on Social Security Reform collapsed and what happened in the final House-Senate conference committee just before the rescue passed."

Social security and the politics of assumptions. Public administration, v. 45, May-June 1985: 363-371.
"Addresses the importance of economic and demographic assumptions in framing the public policy process . . . . Using Social Security as a case study, the article suggests that recent forecasts have been inaccurate for four basic reasons: the social and economic environment, technique, assumption drag, and politics. Nevertheless, the assumptions have been crucial at several key legislative turning points in recent Social Security reforms. The article reviews the impact of political pressure in three specific instances and suggests an emerging pattern in the use and misuse of assumptions. The article concludes with suggestions on how to address the importance of assumptions in the public policy process."

Lomasky, Loren E.
Buying out of social security. Reason, v. 15, Jan. 1984: 33-36.
"Proposes that those who are 45 years old be offered the option of not paying any further Social Security payroll taxes. If they choose this, they would, of course, no longer be eligible upon retirement to benefits. But the money they would save on tax payments would be available to them for investment in private IRAs (individual retirement accounts) or Keogh-plan accounts."

Is social security politically untouchable? Cato journal, v. 5, spring/summer 1985: 157-175.
Finds social security reform proposals to have "political irrelevance." Assesses public sentiment for social security.

Lopata, Helena Znaniecka. Brehm, Henty P.
Widows and dependent wives: from social problem to Federal program. New York, Praeger, 1986. 242 p. (Praeger special studies. Praeger scientific)

Lopez, Eduard A.
Constitutional background in the Social Security Act of 1935. Social security bulletin, v. 50, Jan. 1987: 5-11.
"Although the Social Security Act was passed by overwhelming majorities in both Houses of Congress, there was concern that the Supreme Court would declare the programs unconstitutional. This article discusses the social security cases and the issues that preceded the Court's decision to uphold those provisions. It gives an overview of the constitutional background to the Social Security Act of 1935."

Lubove, Roy.
The struggle for social security, 1900-1935. Pittsburgh, Pa., University of Pittsburgh Press, c1986. 284 p. (Pitt series in policy and institutional studies)

March, Michael S.
An analysis of the development and rationales of the United States income security system, 1776-1980: an analysis for the Select Committee on Aging, House of Representatives, Ninety-seventh Congress, first session. Washington, G.P.O, 1981. 68 p.
At head of title: Committee print. "Comm. pub. no. 97-303."

Maxfield, Linda Drazga.
Income of new retired workers by age at first benefit receipt: findings from the new beneficiary survey. Social security bulletin, v. 48, July 1985: 7-26.

"Examines how income sources and total monthly income received by retired social security beneficiaries vary with the age at which the first benefit check was received."

Distribution of income sources of recent retirees: findings from the New Beneficiary Survey, by Linda Drazga Maxfield and Virginia P. Reno. Social security bulletin, v. 48, Jan. 1985: 7-13.

"Examines income received by the newly retired from assets, employer-provided pensions, and social security. Today's retirees commonly possess pension or asset income to supplement social security . . . . The data also highlights the important role of earnings among many of the new beneficiaries--44 percent of the married couples and 27 percent of the unmarried had current earnings."

McSteen, Martha A.
Fifty years of Social Security. Social Security bulletin, v. 48, Aug. 1985: 36-44.

The Acting Commissioner of Social Security recounts the legislative history of the program in general terms.

Munnell, Alicia H.
Social security and the budget. Federal Reserve Bank of Boston New England economic review, July-Aug. 1985: 5-18.

"The traditional way of measuring the impact of the social security trust funds on the unified budget deficit has significantly understated the amount by which these programs have reduced the Treasury's required borrowing from the private sector. Furthermore, the projected unprecedented buildup of trust fund reserves adds a new and compelling argument to the arsenal of reasons for reporting activities of the social security trust funds separately from the rest of the budget."

Myers, Robert J.
Actual costs of the social security system over the years compared with 1935 estimates. Social security bulletin, v. 45, Mar. 1982: 13-15.

"Indicates that the cost of the Old-Age and Survivors Insurance program in 1980, when expressed as a percentage of taxable payroll, was almost exactly the same as it was estimated initially to be then. Such cost, however, does not include the Disability Insurance and Hospital Insurance programs and, moreover, is estimated to increase by about 50 percent over the next 50 years, whereas the initial estimates showed no cost increases after 1980."

The extent of general revenue financing in the social security program as a result of the 1983 amendments. Employee benefits journal, v. 9, June 1984: 24-26, 33.

Describes and analyzes "the various ways in which general revenue payments have been injected into the financing of the OASDI-HI program by the 1983 Amendments."

Investment policies and procedures of the social security trust funds. Social security bulletin, v. 45, Jan. 1982: 3-7.

"The Deputy Commissioner of Social Security for Programs describes the policies and procedures that have been followed in investing the assets of the Social Security trust funds, explores possible alternative investment areas, and counters criticisms of investment results and maturity duration."

Social security. Published for McCahan Foundation, Bryn Mawr, Pa., by R. D. Irwin, c1985. 1076 p.

National Academy of Public Administration.
The Social Security Administration: management reforms as a part of organizational independence; a report to the Congressional Panel on Social Security Organization. Washington, The Academy, 1984. 48 p.

"Deals with the management problems faced by large operating institutions such as SSA, the management constraints within which SSA must function, and the opportunities which exist to improve SSA's management performance, either as an independent agency or in its current departmental location."

Noah, Timothy.
Notch babies. New republic, v. 195, Dec. 1, 1986: 18, 20-21.
Looks at the formula for determining social security benefits for those born between 1917 and 1921 as well as whether they are "worse-off" than the retirees who preceded them.

The Presidential policy scoreboard. World & I, v. 3, Mar. 1988: 52-64.
Seven Democratic and six Republican Presidential aspirants address the issue of Social Security.

Proposals to deal with the social security notch problem. Washington, American Enterprise Institute for Public Policy Research, 1985. 34 p. (Legislative analysis, no. 51, 99th Congress)
"Describes what the notch problem is and how it arose, emphasizing the reasons for and the nature of the legislation that caused it. It elaborates on the dimensions and character of the inequity, illustrating a number of ways in which it can be viewed. Finally, it discusses a number of bills pending before Congress to deal with the problem and provides arguments for and against enactment of such measures."

Pugh, Robert E.
Forecasting the number of social security retirees: improving forecasts for better policy making. Journal of policy analysis and management, v. 71, fall 1987: 62-73.
Claims that "past and current forecasts by the Social Security Administration (SSA) substantially underestimate future U.S. populations of age 65 and older." Recommends that independent advisory groups be established to help develop an improved 15- to 20-year forecast of the aged. Robert J. Myers comments.

Quinn, Joseph F. Burkhauser, Richard V.
Influencing retirement behavior: a key issue for social security. Journal of policy analysis and management, v. 3, fall 1983: 1-13.
"Recent trends toward earlier retirement threaten future supplies of labor and the financial stability of many of our public and private pension systems. One of the few federal efforts now in place to reverse this trend has been the 1977 law outlawing mandatory retirement before age 70 for most American workers . . . . To be successful, efforts of policymakers to increase work at older ages must focus on the financial incentives at the heart of retirement plans rather than on merely attempting to weaken mandatory retirement constraints."

Rauch, Jonathan.
Congress weighs idea of cuts in social security COLAs that shield the poor. National journal, v. 17, Apr. 27, 1985: 901-904.
Reports on recent proposals concerning COLA. Notes that "nobody is proposing formal means testing of social security, but many are considering roundabout ways to deliver some benefits on the basis of need."

False security. National journal, v. 19, Feb. 14, 1987: 362-365.
Contends that "tapping the social security trust fund's large and growing annual surpluses to reduce the over-all budget deficit could give a false sense of fiscal accomplishment."

Regional and State patterns of population change and benefit receipt, 1980-84. Social security bulletin, v. 49, Apr. 1986: 12-24.
"Contrary to the overall population growth and the growth in the social security beneficiary population, the proportion of persons receiving federally administered supplemental security income (SSI) payments has declined (-2.7 percent), as has the proportion of individuals receiving both social security benefits and SSI payments (-5.3 percent)."

Reno, Virginia P. Price, Daniel N.
Relationship between the retirement, disability, and unemployment insurance programs: the U.S. experience. Social security bulletin, v. 48, May 1985: 24-37.
"Described here are the progression of extended benefit provisions of unemployment insurance through the most recent recession, the historical development of early retirement features in the social security program, and the more recent attention that has been paid to the financing issues that have played a central role in legislation during the late 1970's and early 1980's. Unemployment experience and trends toward early retirement are examined, along with the role of public and private employee pension

plans that supplement social security retirement benefits. Preliminary data from the Social Security Administration's New Beneficiary Survey show the prevalence of such pension coverage for recent retirees and the extent to which these pension benefits were claimed before normal retirement age."

The Report of the Committee on Economic Security of 1935 and other basic documents relating to the development of the Social Security Act; 50th anniversary edition. Washington, National Conference on Social Welfare, c1985. 288 p.

Reprints "a number of government documents from the New Deal era that pertain to the passage of the Social Security Act of 1935 and its early evolution. They include the Report of the Committee on Economic Security of 1935, which laid the groundwork for the Act, the 1935 Act itself, several statements by President Roosevelt expressing his philosophy of the Social Security System, two 1937 Supreme Court decisions that validated the Act, and the Report of the 1937-38 Advisory Council on Social Security and subsequent legislation passed in 1939 that changed the 1935 law in important ways."

Report on earnings sharing implementation study; prepared for the Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives. Washington, G.P.O., 1985. 632 p.

At head of title: 99th Congress, 1st session, committee print no. 99-4.

"Defines earnings sharing as proposals in which 'the combined earnings of a husband and wife during the period of their marriage shall be divided equally and shared between them for social security benefit purposes.'"

Robertson, A. Haeworth.

The social security fix. Across the Board, v. 20, Apr. 1983: 31-39.

Asserts that "the work of the National Commission on Social Security Reform, though politically realistic, was extremely disappointing. Not because it failed to resolve all of Social Security's financial and design difficulties--that would be asking too much--but because it failed to identify and report forcefully the full extent of the system's weaknesses so that the Congress and the public would know that such frightening weaknesses do exist."

Rogers, Helen P.

Social security: an idea whose time has passed. Carmel, Calif., Wellington Publications, c1985. 93, 46 p.

Ross, Mary. Hayes, Carol.

Consolidated Omnibus Budget Reconciliation Act of 1985. Social security bulletin, v. 49, Aug. 1986: 22-31.

"Briefly describes the legislative history of the old-age, survivors, and disability insurance (OASDI) and supplemental security income (SSI) provisions, as well as related Medicare and Medicaid provisions, of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272). It includes a chronology outlining the interaction of the budget reconciliation process with the development of the OASDI minor and technical changes bill (H.R. 2005) and the development of other social security related legislation resulting in proposals that utlimately combined in the overall Consolidated Omnibus Budget Reconciliation Act of 1985."

Rubin, Leona G.

Your 1987/88 guide to social security benefits. Rev. ed. New York, Facts on File Publications, c1987. 194 p.

Sammartino, Frank J.

The effect of health on retirement. Social security bulletin, v. 50, Feb. 1987: 31-47.

"After reviewing the specific effects of the 1983 Social Security amendments on future retirement benefits, it presents a theoretical model of retirement timing that includes the influence of health and the effects of social security benefits."

Saving social security. New York, H. W. Wilson Company, 1982. 158 p. (Reference shelf, v. 54, no. 4)

Partial contents.--Social security: what is it?--Understanding the problems.--The reform debate.--Plenty of reaction, but no solution.

Scherschel, Patricia M. DeLouise, Richard L.
Social security at 50 faces new crossroads. U.S. news & world report, v. 99, Aug. 12, 1985: 40-45.
"Among the old and the not-so-old, a crisis of confidence in the social security system is a growing danger."

Seidman, Laurence S.
Social security and demographics in a life cycle growth model. National tax journal, v. 36, June 1983: 213-224.
"Suppose there is a permanent decline in the growth rate of population, or of labor productivity; or an increase in the age of death. What would be the impact on the steady-state of the economy, and of the 'pay-as-you-go (PAYG)' Social Security (SS) program?"

Shapiro, Robert Y. Smith, Tom W.
The polls: social security. Public opinion quarterly, v. 49, winter 1985: 561-572.
Compares trends in results of fifteen national polls on social security.

Smith, Ralph E. Kasten, Richard A.
Earnings sharing options for the social security system; CBO study. Washington, Congressional Budget Office, 1986. 137 p.
Examines the methodologies, recommendations, and analyses used in a report prepared by the Department of Health and Human Services on using earnings sharing for calculating social security benefits.
Partial contents.--Assessment of the HHS study and overview of the CBO report.--Issues regarding treatment of two-earner couples, divorced women, and widows.--Earnings sharing plans and criteria for their assessment.--Analysis of earnings sharing plans.--Comparison of packages of incremental options.--Budgetary impact of the HHS plans.

Social security: a critique of radical reform proposals. Edited by Charles W. Meyer. Lexington, Mass, Lexington Books, c1987. 153 p.
Contents.--Social security, by Charles W. Meyer.--Phasing out social security, by Bruno Stein.--Intercohort and intracohort redistribution under social security, by Charles W. Meyer and Nancy L. Wolff.--Social security and private saving, by Selig D. Lesnoy and Dean R. Leimer.--Labor market behavior of older workers approaching retirement, by Rachel Floersheim Boaz.--The economic and political implications of a phase-out, by Charles W. Meyer.

Social security: a financial appraisal across and within generations. Cambridge, Mass., National Bureau of Economic Research, 1986. 37 p. (NBER working paper no. 1891)
"Computes the expected present value of Social Security retirement benefits and taxes for households of different marital circumstances, incomes, and age cohorts. Also computed are the net gain or loss from participation in the system and the expected internal rate of return it offers various participants. The paper calculates the marginal linkage between benefits and contributions, and also examines how the age of entry into the covered workforce affects the participants."

Social security after fifty: successes and failures. Edited by Edward D. Berkowitz. New York, Greenwood Press, 1987. 168 p. (Studies in social welfare policies and programs, 8755-5360; no. 5)

Social security and retirement: private goals, public policy. Washington, Congressional Quarterly, 1983. 246 p.
Partial contents.--Social security: the funding crisis.--Private pension plans and retirement income.--Public pension plans.

Social security: continuing crisis or real reform? Cato journal, v. 3, fall 1983: 335-621.
Partial contents.--Social security survival: a public-choice perspective.--The economics and politics of the emergence of social security: some implications for reform.--The National Commission's failure to achieve real reform.--Funded social security: collective and private options.

Social security: fiftieth anniversary collection. Social Security bulletin, v. 48, Aug. 1985: 5-35.
Former Commissioners of Social Security and others related to the program give insights into the system's development in this collection of essays.

Social security, Medicare, and the unified budget; report prepared by the Congressional Research Service for the Committee on the Budget, United States Senate. Washington, G.P.O., 1985. 112 p. (Report, Senate, 99th Congress, 1st session, S. Prt. 99-83)

Social security programs in the United States, 1987. Social security bulletin, v. 50, Apr. 1987: 5-66.
"Provides a layman's guide to the Nation's network of publicly funded cash and in-kind income maintenance programs and the health insurance and medical assistance programs of the Social Security Act."

Social security programs in the United States. Social security bulletin, v. 49, Jan. 1986: 5-59.

Social security; Project on the Federal Social Role. Washington, National Conference on Social Welfare, c1985. 22 p. (Working paper: Project on the Federal Social Role; 4)
Contents.--The future of Social security, by James Tobin.--Social security and constitutional entitlement, by Robert M. Cover.

Social security: prospects for real reform. Edited by Peter J. Ferrara. Washington, Cato Institute, c1985. 220 p.
Partial contents.--Rates of return promised by social security to today's young workers.--Social security: myths and realities.--The economics and politics of the emergence of social security: some implications for reform.--Achieving a political strategy for reform.

Solon, Michael.
Talking points on social security and the budget. Washington, Republican Study Committee, 1985. 10 p.
Contents.--Social security and the budget proposal.--Social security and budget fairness.--Social security and tax fairness.--Social security and elderly finances.--Social security and inflation.--Social security and future solvency.--Social security and political demagoguery.

Special topic: privatization. Journal of policy analysis and management, v. 6, summer 1987: 523-696.
Partial contents.--Privatization of public-sector services in theory and practice.--Justifying public provision of social security.

Stang, Alan.
Mr. Reagan: it is time to abolish social security. American opinion, v. 27, Nov. 1984: 21-28, 77, 79-80.
Contends that "social security is expected to collapse in the mid 1990s. The 1977 'solution' involved a tax increase of $227 billion over ten years, and the 1983 bailout calls for massive tax increases in 1988 and 1990. To pay the benefits promised young workers, payroll tax rates may have to be raised more than forty percent."

Steiner, Kenneth A.
The social security illusion. Journal of pension planning and compliance, v. 10, Apr. 1984: 155-159.
Lists facts pertaining to the financing of the social security system which have lead the author to conclude "that the Social Security Amendments of 1983 will probably not solve the system's financial problems for the next 75 years, as has been claimed."

Stewart, Alva W.
Social security: its development from Roosevelt to Reagan. Monticello, Ill., Vance Bibliographies, 1982. 13 p. (Public administration series: bibliography P-964)

A Study of the implementation of earnings sharing in the United States' social security system. International social security review, no. 4, 1985: 367-377.
"Summarises the report on the study of the implementation of earnings sharing mandated by the Social Security Amendments of 1983. Earnings sharing is a concept meaning that a married couple shares equally any earnings credited for social security purposes during the years of their marriage."

Svahn, John A.
Restoration of certain minimum benefits and other OASDI program changes: legislative history and summary of provisions. Social security bulletin, v. 45, Mar. 1982: 3-12.
"The Commissioner of Social Security traces the legislative development of these and other provisions contained in the new law Omnibus Budget Reconciliation Act."

Social security amendments of 1983: legislative history and summary of provisions, by John A. Svahn and Mary Ross. Social security bulletin, v. 46, July 1983: 3-48.

Thompson, Lawrence H.
The social security reform debate. Journal of economic literature, v. 21, Dec. 1983: 1425-1467.
"Reviews suggestions for reform of the Social Security retirement program and offers some observations about why reform efforts have met with so little success."

Thornborrow, Nancy.
Social security's effect on retirement assets. Quarterly journal of business and economy, v. 24, spring 1985: 51-72.
"For the cohort of workers studied, social security means an average reduction in assets of $9,306 at the time of retirement. On average these workers paid $2,901 in social security contributions. Some workers, in fact, reduced their real and financial assets by substantially more than their payments into the system. Because social security contributions are paid as benefits, they are not invested in capital markets. Therefore, the social security system does not accumulate assets equal in value to promised future benefits. For this reason, aggregate saving also declines."

U.S. Congress. Conference Committees, 1983.
Social security amendments of 1983; conference report to accompany H.R. 1900. Washington, G.P.O., 1983. 207 p. (Report, House, 98th Congress, 1st session, no. 98-47)

U.S. Congress. House. Committee on Appropriations. Subcommittee on the Departments of Labor, Health and Human Services, Education, and Related Agencies.
Departments of Labor, Health and Human Services, Education, and related agencies appropriations for 1987. Hearings, 99th Congress, 2nd session. Washington, G.P.O., 1986. 1428 p.
Part 5 includes the Social Security Administration; Health Care Financing Administration.

U.S. Congress. House. Committee on Ways and Means.
Background material and data on programs within the jurisdiction of the Committee on Ways and Means. Washington, G.P.O., 1987. 947 p.
At head of title: 100th Congress, 1st session, committee print, WMCP: 100-4.
Covers social security, Medicare, and public assistance programs.

Recommendations of the National Commission on Social Security Reform. Hearings, 98th Congress, 1st session. Feb. 1-3, 1983. Washington, G.P.O., 1983. 256 p.
"Serial 98-3"

Social Security Administrative and Investment Reform Act of 1986; report to accompany H.R. 5050 including cost estimate of the Congressional Budget Office. Washington, G.P.O. 1986. 305 p. (Report, House, 99th Congress, 2nd session, no. 99-680)

Social security cost-of-living increase. Hearing, 98th Congress, 2nd session. Sept. 20, 1984. Washington, G.P.O., 1985. 41 p.
"Serial 98-106"

Summary of committee decisions on the Social Security Act amendments of 1983 (H.R. 1900). Washington, G.P.O., 1983. 13 p. (Print, House, 98th Congress, 1st session, committee print WMCP: 98-6)

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security.
Delivery and quality of public services furnished by the Social Security Administration. Hearings, 99th Congress, 1st session. Washington, G.P.O., 1985. 293 p.
"Serial 99-19"
Hearings held in Washington, D.C., Apr. 3, 1985 and Tulsa, Okla., Apr. 11, 1985.

Disinvestment of the social security trust funds to finance the public debt. Hearing, 99th Congress, 1st session. Oct. 30, 1985. Washington, G.P.O., 1986. 47 p.
"Serial 99-52"

Disinvestment of the social security trust funds to finance the public debt. Washington, G.P.O., 1985. 68 p.
At head of title: 99th Congress, 1st session. Committee print WMCP:99-12.

Quality of delivery of services by the Social Security Administration, disinvestment of the social security trust funds, and the Social Security Administration as an independent agency. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 57 p.
Hearing held Jan. 27, 1986, Oklahoma City, Okla.
"Serial 99-64"

Retirement income security in the United States. Hearings, before the Subcommittee on Social Security and the Subcommittee on Oversight of the Committee on Ways and Means, House of Representatives, 99th Congress, 1st session. Washington, G.P.O., 1986. 927 p.
"Serial 99-50"
Hearings held on July 18; September 5 and 6, 1985.

Social security as an independent agency. Hearing, 99th Congress, 1st session on H.R. 825. Apr. 23, 1985. Washington, G.P.O., 1985. 160 p.
"Serial 99-23"

Staffing reductions, service delivery, and management of the Social Security Administration. Hearing, 100th Congress, 1st session. Apr. 2, 1987. Washington, G.P.O., 1987. 324 p.
"Serial 100-20"

U.S. Congress. House. Select Committee on Aging.
Back to basics: social security off-budget and independent. Hearing, 99th Congress, 1st session. Sept. 9, 1985. Washington, G.P.O., 1985. 83 p.

Reductions in social security benefit levels: the notch. Hearing, 99th Congress, 2nd session. May 15, 1986. Washington, G.P.O., 1986. 59 p.
"Comm. pub. no. 99-600"

Women's pension equity. Hearing, 98th Congress, 1st session. June 14, 1983. Washington, G.P.O., 1983. 369 p.
"Comm. pub. no. 98-401"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Human Services.
Proposals for social security reform: an Idaho perspective. Washington, G.P.O., 1983. 210 p.
At head of title: Committee print.
"Comm. pub. no. 98-391"

U.S. Congress. House Select Committee on Aging. Subcommittee on Retirement Income and Employment.
Reductions in social security benefit levels: the notch. Hearing, 100th Congress, 1st session. Vol. 7. Washington, G.P.O., 1987. 201 p.
"Comm. pub. no. 100-626"
Hearing held Apr. 24, 1987 in Cleveland.

Social security beneficiary services. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1986. 47 p.
"Comm. pub. no. 99-536"
Hearing held Sept. 24, 1985, Cedar Rapids, IA.

Social security earning records: are they being credited properly? Hearing, 100th Congress, 1st session. Oct. 15, 1987. Washington, G.P.O., 1988. 59 p.
"Comm. Pub. No. 100-648"

Status of the social security system and the problems of the rural elderly; a briefing. Washington, G.P.O., 1983. 97 p.
At head of title: Committee print.
"Comm. pub. no. 97-350"
Hearings held in Wytheville, Va., July 6, 1982 and Clinchco, Va., July 8, 1982.

U.S. Congress. Joint Economic Committee. Subcommittee on Economic Goals and Intergovernmental Policy.
Social security system. Hearing, 98th Congress, 2nd session. Sept. 25, 1984. Washington, G.P.O., 1985. 131 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-1233)

U.S. Congress. Senate. Committee on Finance.
Staff data and materials related to social security financing. Washington, G.P.O., 1982. 67 p.
At head of title: 97th Congress, 2nd session. Committee print CP 97-19.
"Describes the current manner of financing the social security programs, the means by which financial soundness is measured, and the current financial condition of the system both in the short and long term."

U.S. Congress. Senate. Committee on Finance. Subcommittee on Social Security and Income Maintenance Programs.
National Commission on Social Security Reform recommendations. Hearings, 98th Congress, 1st session. Feb. 15-24, 1983. Washington, G.P.O., 1983. 3 v. (219, 660, 870 p.) (Hearings, 98th Congress, 1st session, S. Hrg. 98-87; 98-130; 98-89)

Review of social security trust fund policy. Hearing, 99th Congress, 1st session. Nov. 7, 1985. Washington, G.P.O., 1986. 50 p. (Hearing, Senate, 99th Congress, 1st session, S. Hrg. 99-528)
Reviews "the policy and procedures followed by the Secretary of the Treasury in investing and redeeming Social Security Trust Fund assets."

U.S. Congress. Senate. Special Committee on Aging.
Social security: how well is it serving the public? Hearing, 98th Congress, 1st session. Nov. 29, 1983. Washington, G.P.O., 1984. 139 p. (Hearing, Senate, 98th Congress, 1st session, S. Hrg. 98-805)

U.S. Congressional Budget Office.
Financing social security: issues and options for the long run. Washington, For sale by the Supt. of Docs., G.P.O., 1982. 112 p.

U.S. Congressional Budget Office.
Reducing the deficit: spending and revenue options. Washington, C.B.O., for sale by the Supt. of Docs., G.P.O., 1984. 276 p.
Provides background information for each major spending area of the budget including social security and medicare and analyzes various specific options that would reduce the deficit."
"A report to the Senate and House Committees on the Budget--Part III, as required by Public Law 93-344."

U.S. Congressional Panel on Social Security Organization.
A plan to establish an independent agency for social security: a study prepared for the Committee on Ways and Means, United States House of Representatives and the Committee on Finance, United States Senate, pursuant to P.L. 98-21. Washington, G.P.O., 1984. 122 p.

At head of title: Committee print, S. Prt. 98-204

The joint study panel, chaired by Elmer Staats, was charged with making a "thorough study with respect to the implementation of removing the Social Security Administration from the Department of Health and Human Services and establishing it as an independent agency in the executive branch with its own independent administration structure . . . . Though the Panel's recommendation presume independence, they should not be interpreted as an endorsement of it."

U.S. General Accounting Office.
Demographic and economic characteristics of social security retiree families: study by the staff of the U.S. General Accounting Office. [Washington] 1982. 61 p.

"GAO/HRD-82-131, Sept. 28, 1982"

"The data show various characteristics, such as family size, age, marital status, and income of social security retirees, their spouses, and children. Special emphasis is placed on newly entitled retiree families."

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Issues concerning social security benefits paid to aliens: report to the Congress by the Comptroller General of the United States. Washington, G.A.O., 1983. 25 p.

"GAO/HRD-83-32, Mar. 24, 1983"

"Examines the circumstances under which social security benefits are paid to alien retirees and dependents living abroad and discusses the characteristics of this beneficiary group. The report also presents information concerning aliens who, while working in violation of the Immigration and Nationality Act, can earn social security credits."

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Need to strengthen social security's beneficiary reporting requirements and enforcement authority: report to the Congress by the Comptroller General of the United States. Mar. 22, 1985. Washington, G.A.O., 1985. 67 p.

"GAO/HRD-85-12"

"The failure of retired and disabled beneficiaries and their dependents or survivors to properly report benefit-affecting circumstances often causes overpayments that in the aggregate are costly to the Social Security Administration (SSA). This review tries to determine what portion of the overpayments are caused by beneficiaries and how effectively SSA is using its sanctions to prevent and minimize improper reporting."

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Retirement benefits: discrepancies in benefits paid by the Railroad Retirement Board for SSA; report to the acting commissioner of Social Security and the chairman of the Railroad Retirement Board. Feb. 1986. Washington, G.A.O., 1986. 21 p.

"GAO/HRD-86-3"

"Surveyed 17 different types of data exchanges between the Railroad Retirement Board (RRB) and the Social Security Administration (SSA) and focused on the most problematic--the benefit payments made by RRB on behalf of SSA."

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Social security: actions and plans to reduce agency staff; briefing report to congressional requesters. Mar. 1986. Washington, G.A.O., 1986. 22 p.

"GAO/HRD-86-76BR"

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Social Security Administration: questionnaire responses from mid-level managers and employees; staff study. July 1, 1987. Washington, G.A.O., 1987. 36 p.

"GAO/HRD-87-72"

"In June 1986, we mailed a questionnaire to 813 Social Security Administration (SSA) mid-level managers. The purpose of the questionnaire was to obtain the managers' perspectives on the continued existence of previously identified problems at SSA and potential problem areas identified by researchers who have studied large organizations."

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Social Security Administration: stable leadership and better management needed to improve effectiveness; report to the Congress. Mar. 18, 1987. Washington, G.A.O., 1987. 248 p.
"GAO/HRD-87-39, B-226762"
GAO found that "SSA has serious management problems" and recommends that "SSA needs: both strong and stable leadership, a condition that has not existed for the past decade; . . . better management of its effort to modernize SSA computer systems; . . . better planning to prepare for a future in which its operational and human resource needs are likely to change; . . . more focus on financial management; . . . better controls over service delivery to identify inefficient and ineffective operations; and better work force management to improve the work climate."

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Social security: clients still rate quality of service high; briefing report to congressional requesters. July 14, 1987. Washington, G.A.O., 1987. 27 p.
"GAO/HRD-87-103BR, B-226456"
"Presents the final results of our November 1986 nationwide survey of client satisfaction with the quality of service provided by the Social Security Administration (SSA) and compares the results with a similar survey we conducted 2 years earlier . . . . Comparing the results of the two surveys . . . shows that clients rated the overall quality of service in 1986 about the same as or better than the service provided in 1984. Notably, no specific service aspects were rated significantly lower by 1986 respondents in comparison with 1984 respondents, and a number of service aspects were rated higher."

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Social security: improved telephone accessibility would better serve the public; report to the Secretary of Health and Human Services. Aug. 1986. Washington, G.A.O., 1986. 44 p.
"GAO/HRD-86-87"
"This report, one of a series on SSA's service to the public, discusses the results of a GAO nationwide test of SSA telephone access and provides information on the agency's standards and telephone reporting activities. . . . GAO recommends that SSA: establish telephone service standards for all facilities handling calls from the public; clarify the standard for average wait time to require that only calls on hold be used in computing the average; periodically measure the accessibility of SSA telephone answering facilities against established standards; and take steps to bring into compliance those facilities not meeting established standards."

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Social security: more must be done to credit earnings to individuals' accounts; report to congressional committees. Sept. 18, 1987. Washington, G.A.O., 1987. 70 p.
"GAO/HRD-87-52, B-226637"
" Recommends that the Secretaries of HHS and the Treasury direct the Commissioners of Social Security and Internal Revenue to develop and pursue a strategy for examining the backlogged and newer cases and report their plans to the Congress and determine the major causes of recording differences in SSA and IRS earnings totals and take corrective action to prevent their occurrence or reduce their frequency."

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Social security: past projections and future financing concerns; report to Congressional requesters. Mar. 1986. Washington, G.A.O., 1986. 50 p.
"GAO/HRD-86-22"
"Reviews past and current projections for the Social Security system and the economic and demographic assumptions, adopted by the Board of Trustees, that underlie the projections."

_____.

Social security: payment accuracy rates are overstated; report to the Chairman, Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations, U.S. Senate. Oct. 29, 1987. Washington, G.A.O., 1987. 38 p.
"GAO/HRD-88-16, B-228108"
Discusses accuracy of payments "to more than 38 million retirees, survivors, and dependents. The report also describes how the agency monitors its payment accuracy and reports to the Congress on its performance."

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U.S. National Commission on Social Security. [illegible]

U.S. Social Security Administration. Office of [illegible]

[illegible]

[illegible]

[illegible]

Work, health, and income among the elderly. Edited by Gary Burtless. Washington, Brookings Institution, c1987. 276 p.

THE SUPPLEMENTAL SECURITY INCOME PROGRAM

Baskerville, Valerie G.
Supplemental security income; State and county data: December 1986. Washington, U.S. Social Security Administration, Office of Policy, Office of Research and Statistics, 1988. 159 p. (SSA publication no. 13-11976)
Presents information by State and county about persons who received a Federally administered Supplemental Security Income (SSI) payment during December 1986. The tables show recipient counts and total Federal SSI and Federally administered State supplementation benefits by eligibility status (aged, blind, or disabled).

Burkhauser, Richard V. Smeeding, Timothy M.
The net impact of the social security system on the poor. Public policy, v. 29, spring 1981: 159-178.
"Shows that the current structure of SSI has altered significantly the 'social insurance-social welfare' nature of OASI for many low-income workers." Also "shows that while a reduction in the net tax (benefit reduction) rate on OASI in SSI would increase SSI expenditure, it would also result in removing a large number of low-income elderly people from the poverty rolls."

Completing the long-term care continuum: an income supplement strategy. Washington, Center for the Study of Social Policy (1250 Eye St. N.W., 20005), 1988. [235] p.
Provides in-depth profiles of State SSI supplement programs in California, Colorado, Maryland, Michigan, Texas, Virginia, and Wisconsin. Asks, "Does an income supplementation strategy possibly offer the kind of individualized, flexible and need-targeted resource that will best contribute to a desirable long term care system? What are its specific problems and limitations, how can it be integrated with health care, housing and social services?"

Drazga, Linda. Upp, Melinda. Reno, Virginia.
Low-income aged: eligibility and participation in SSI. Social security bulletin, v. 45, May 1982: 28-35.
"Reports on a study undertaken to evaluate the Social Security Administration's (SSA) methods for estimating the number of persons eligible for Federal Supplemental Security Income (SSI) payments."

Duggan, James E.
The labor-force participation of older workers. Industrial & labor relations review, v. 37, Apr. 1984: 416-430.
Analyzes "the effect of . . . cohort crowding and Supplemental Security Income (SSI)" on the decision to participate in the labor force made by persons over 54 years old.

Farrell, William Parent, Rene. Tenney, Michael.
Administration and service delivery in the SSI program: the first 10 years. Social security bulletin, v. 47, Aug. 1984: 3-22.
"Provides an overview of the administrative structures and processes through which the Social Security Administration delivers its services to Supplemental Security Income (SSI) claimants and recipients . . . . Among the subjects covered are the legislative history of the program, the claims process, posteligibility procedures, underpayments and overpayments, the administrative complexities that have had to be surmounted, and administrative efforts aimed at quality assurance."

Grimaldi, Paul L.
Supplemental security income: the new Federal program for the aged, blind, and disabled. Washington, American Enterprise Institute for Public Policy Research, c1980. 119 p. (AEI studies, 253 Studies in social security and retirement policy)

Grundmann, Herman F.
Adult assistance programs under the Social Security Act. Social security bulletin, v. 48, Oct. 1985: 10-21.
Reviews the history of old age assistance from 1935 through the enactment of the supplemental security income program.

Hawkins, Sue C.
SSI: trends in state supplementation, 1979-81. Social security bulletin, v. 46, June 1983: 3-8.
Updates a report on the first 5 years of State supplementation programs under SSI and focuses on changes that took place from December 1979 to December 1981.

Kahn, Arthur L.
Program and demographic characteristics of supplemental security income recipients, December 1985. Social security bulletin, v. 50, May 1987: 23-57.
Focuses on recipients of the Federal program for the nation's needy "who, in addition to being poor, were also aged, blind, or disabled." Charts "reasons for eligibility, payment distribution, sex, age, race, income, resources, living arrangements, and metropolitan residency. Provisions of the federally administered program, including the basic eligibility requirements--updated through January 1987--are also presented."

Kennedy, Lenna.
SSI: trends and changes, 1974-80. Social security bulletin, v. 45, July 1982: 3-12.
"Since 1975, both SSI payments and Social Security benefits have been automatically adjusted each year to correspond with increases in the Consumer Price Index. A number of other trends in addition to growth can be discerned in the size of the population served, as well as in their categorical, geographic, and age distributions. This article discusses some of these trends and changes, using program data for the end of each calendar year through 1980. It also presents a brief summary of the program at the end of that period."

Martin, Peter W.
Procedures used in forming and carrying out Federal-state agreements under the supplemental security income program. In U.S. Administrative Conference. Recommendations and reports, 1979. Washington, For sale by the Supt. of Docs., G.P.O., [1981] p. 71-202.
"Analyzes the basic legal relationship created by the provision for Federal administration of state supplementary benefits."

Pupp, Roger L. Menefee, John.
Public transfer support and income adequacy among the low-income aged. Policy studies journal, v. 12, Sept. 1983: 62-78.
Analyze the effect of four policy proposals "on the economic well-being and poverty status of the low-income aged by employing a 1974 Social Security Administration (SSA) sample. The proposed changes are a restructuring of the SS benefit formula, an increase in the SSI benefit level, including the annuity value of net worth in SSI countable income, and a mandatory defined contribution pension plan."

Rigby, Donald E. Ponce, Elsa.
The supplemental security income program for the aged, blind, and disabled. [Washington] U.S. Social Security Administration, for sale by the Supt. of Docs., G.P.O., 1982 [i.e. 1983] 99 p. (SSA publication no. 13-11975)
"Focuses on eligibility provisions and basic levels of assistance for individuals and couples who receive supplementary payments in the 50 States and the District of Columbia. Data on Federal-State administrative responsibilities for making payments and on State criteria for emergency or special need payments are also presented."

Scott, Charles G. Mulberg, Ruthellen. Oberheu, Howard.
SSA's outreach efforts to contact beneficiaries eligible for SSI payments. Social security bulletin, v. 51, Jan. 1988: 12-17.

Supplemental Security Income Study Group (U.S.)
Report of the Commissioner of Social Security and the Secretary of Health, Education, and Welfare on the supplemental security income program. Washington, U.S. Social Security Administration, 1976. 283 p. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (SSA) 76-10609)
Studied "the Federal and state roles, eligibility criteria, service to the client, management and administration, program quality, and computer systems."

Taubman, Paul J. Sickles, Robin C.
Supplemental social insurance and the health of the poor. Cambridge, Mass., National Bureau of Economic Research, 1983. 21 p. (Working paper no. 1062)
Concludes that "before 1974 those who subsequently received SSI were in much worse health than those who did not. After 1974 the differences in health were small and not statistically significant."

Trout, John. Mattson, David R.
A 10-year review of the Supplemental Security Income program. Social security bulletin, v. 47, Jan. 1984: 3-24.
"Reviews the development of the program since its enactment and compares the program's performance with its original goals and expectations."

U.S. Congress. House. Committee on Government Operations. Intergovernmental Relations and Human Resources Subcommittee.
Social security disability insurance and supplemental security income programs. Hearing, 99th Congress, 1st session. Dec. 11, 1985. Washington, G.P.O., 1986. 220 p.

U.S. Congress. House. Committee on Ways and Means.
Asset verification and other improvements in AFDC and SSI programs; report to accompany H.R. 5362 including the cost estimate of the Congressional Budget Office. Washington, G.P.O., 1984. 64 p.

Elimination of minimum social security benefit under Public Law 97-35. Hearing, 97th Congress, 1st session. Sept. 10, 1981. Washington, G.P.O., 1981. 57 p.
"Serial 97-22"

SSI improvement amendments of 1986; report to accompany H.R. 5595 including cost estimate of the Congressional Budget Office. Washington, G.P.O., 1986. 21 p. (Report, House, 99th Congress, 2nd session, no. 99-893)

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Public Assistance and Unemployment Compensation.
Elements in the report of the National Commission on Social Security Reform affecting SSI recipients. Hearing, 98th Congress, 1st session. Feb. 9, 1983. Washington, G.P.O., 1983. 22 p.

Proposals to improve the supplemental security income program. Hearing, 99th Congress, 2nd session. Sept. 17, 1986. Washington, G.P.O., 1986. 49 p.
"Serial 99-88"

SSI equitable improvements and reform amendments of 1984. Hearing, 98th Congress, 2nd session on H.R. 5341. May 9, 1984. Washington, G.P.O., 1985. 180 p.
"Serial 98-110"

U.S. Congress. House. Select Committee on Aging.
Abolishing poverty along older Americans. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 72 p.
Hearing held July 18, 1987, Boston, MA.
"Comm. pub. no. 100-6371"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment.
The forgotten safety net: the supplemental security income (SSI) program. Hearing, 100th Congress, 1st session. Sept. 10, 1987. Washington, G.P.O., 1988. 134 p.
"Comm. pub. no. 100-642"

U.S. Congress. Senate. Special Committee on Aging.
The supplemental security income program: a 10-year overview; an information paper prepared for use by the Special Committee on Aging, U.S. Senate. Washington, G.P.O., 1984. 266 p.
At head of title: 98th Congress, 2nd session. Committee print.

A 10th anniversary review of the SSI program. Hearing, 98th Congress, 2nd session. May 17, 1984. Washington, G.P.O., 1984. 159 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-991)

Welfare law symposium. Cornell law review, v. 65, June 1980: 748-943.
Partial contents.--The art of decoupling: keeping social security's promise up-to-date.--SSI treatment of in-kind income--the one-third reduction rule.

TAXATION AND THE AGED

Berin, Barnet N.
Prevent the mugging of private employee benefits. Across the Board, v. 21, Dec. 1984: 52-58.
Concludes that "if employer contributions are taxed, inevitably benefits will be reduced. Assuming that these benefits are necessary, and that they are not being abused, any reductions will have to be made up by either the employee or by government--or forgone. The country cannot afford to place at risk the health and financial security of an aging population."

Bowman, John H.
Property tax circuit breakers reconsidered: continuing issues surrounding a popular program. American journal of economics and sociology, v. 39, Oct. 1980: 355-372.
"Property tax circuit-breaker programs--provision for tax relief for selected groups of the population believed to be adversely affected by rising state and local taxation on residences--exist in 30 states and the District of Columbia. They are still in controversy. The best available evidence on some of the basic issues being debated is considered in an effort to evaluate their policy implications. The device is found to be desirable and, if the residential property tax were regressive in certain respects, a move in the direction of tax equity. 'Current income' is found more useful in determining eligibility; net worth tests would be difficult to apply. Relief for tax burdens above an acceptable share of household income is preferable to one based on a sliding scale formula. However, the tendency clearly is to liberalize benefits. This creates the danger of eroding the tax base."

Campbell, Alan D.
Minimizing the self-employment tax. Tax adviser, v. 17, May 1986: 271-276.
"The self-employment tax--a social security tax imposed on net earnings from self-employment--can be quite a burden to the self-employed person. However, a number of techniques may be used to minimize this tax. These include planning around the $400 floor and the annual ceiling ($42,000 in 1986), using accelerated depreciation, hiring one's spouse and/or minor children, and incorporating as an S corporation. Taxpayers should note, however, that minimizing self-employment taxes may lead to lower social security benefits on retirement and should take this into consideration when planning for the future."

Chernick, Howard. Reschovsky, Andrew.
The taxation of social security. National tax journal, v. 37, June 1985: 141-152.
"Starting in 1984, up to one-half of social security benefits of taxpayers with incomes above a threshold level are taxable under the federal income tax. Using household data from the Current Population Survey in conjunction with a highly detailed simulation model of the federal income tax, this study provides an ex ante assessment of this new tax. The analysis shows that only 8 percent of all filing units who receive social security benefits will actually face higher tax liabilities, and that although the taxation of social security increases tax burdens of many moderate and high income elderly, they retain their fiscal advantage over nonelderly taxpayers of similiar income."

Chin, Felix.
Circuit breaker property tax relief: a selected bibliography. Monticello, Ill., Vance Bibliographies, 1982. 11 p. (Public administration series: bibliography P-968)

Council of State Governments.
State tax relief for the elderly: determining the costs. Lexington, Ky. [1976] 77 p.
"The major objective of this report is to develop and test usable methods for estimating the potential tax cost to a State of providing tax relief measures for the elderly." Includes cost calculations for Colorado, Connecticut, and Illinois.

Galper, Harvey. Byce, Charles.
Individual retirement accounts: facts and issues. Tax notes, June 2, 1986: 917-921.
The authors "examine the Senate Finance Committee's proposal to limit deductible IRA contributions to those taxpayers who are not covered by an employer-provided pension plan. They conclude that, despite the intense opposition this proposal has generated, it is a sound one. The concentration of IRA tax benefits at the upper end of the income scale, the differences in contributions to IRAs within income classes, and the relatively small positive effects IRAs have had on the nation's savings rate argue strongly for limiting the deduction and using the revenue to reduce rates across the board."

Gropper, Diane Hal.
Washington's attack on pensions. Institutional investor, v. 19, Jan. 1985: 53-62.
Examines potential pension and benefit changes as part of a general tax reform package.

Hira, Labh S.
Simplified employee pensions: an alternative to qualified plans. Tax adviser, v. 17, May 1986: 264-270.
"Compares simplified employee pensions to qualified plans, pointing out the advantages and disadvantages of each, and explains how to set up and maintain simplified employee pensions under the special rules that apply to them."

Korczyk, Sophie M.
Retirement security and tax policy. Washington, Employee Benefit Research Institute, c1984. 136 p.
"An EBRI-ERF policy study"
Partial contents.--Employee benefits: categories, trends, and tax policy. --Statutory provisions for the tax treatment of pensions.--The tax system and other factors encouraging pension growth.--The measurement of pension-related tax benefits.--Pensions, savings, and financial markets.

Long-term effects of tax reform on retirement income: many unanswered questions. [Washington] Employee Benefit Research Institute, 1987. 19 p. (EBRI issue brief no. 64)
"Investigates the extent to which specific tax reform provisions may alter future pension income."

Nave, David R.
Loans from qualified define contribution plans for tax reform. Taxes, v. 65, Apr. 1987: 267-270.
"The author believes that, although the changes brought about by the Tax Reform Act of 1986 to loans from defined contribution plans have reduced the attractiveness of qualified loans, a properly structured loan provision can still provide a means for plan participants to withdraw their funds from the plan efficiently, for both tax and financial purposes."

Newman, Sandra J. Reschovsky, James D.
Federal policy and the mobility of older homeowners. Journal of policy analysis and management, v. 6, spring 1987: 402-416.
"Evaluates the extent to which the one-time capital gains exclusion provisions succeeds in generating greater mobility among older homeowners."

On your retirement: tax and benefit considerations. Chicago, Ill. Commerce Clearing House, c1986. 104 p.
"CCH editorial staff publication."

O'Neil, Cherie J.
Tax planning for retirement distributions after the Tax Reform Act of 1986. Taxes, v. 65, Sept. 1987: 611-622.

"The author discusses tax-planning techniques that minimize the tax expense upon withdrawal of retirement funds in light of the changes brought by the Tax Reform Act of 1986."

Ozanne, Larry. Lindeman, David.
Tax policy for pensions and other retirement saving. Washington, U.S. Congressional Budget Office, for sale by the Supt. of Docs., G.P.O., 1987. 159 p.
"The federal government encourages pensions, other employer retirement plans, and Individual Retirement Accounts through preferences in the federal income tax. These arrangements have been major focuses of legislation in recent years. This paper reviews the evolution of these tax-advantaged means of retirement saving and appraises their impact on saving and on retirement incomes."

Rappaport, Anna M.
New ideas in employee benefits planning. Journal of pension planning & compliance, v. 13, spring 1987: 41-71.
"Employee benefits today typically represent 20% to 30% of personnel-related expenses, including salary. Thus, employer-sponsored benefits programs play a major role in the financial security of Americans . . . . Federal public policy has been a significant factor in the growth and development of these programs, and has been generally supportive of the types of financial security plans that have been offered over the last 50 years. However, recent tax legislation demonstrates that major changes in public policy are occurring."

Regan, John J.
Tax, estate & financial planning for the elderly. New York, M. Bender, 1985-. 1 v. (loose-leaf)

Sammartino, Frank J. Kasten, Richard A.
The distributional consequences of taxing social security benefits: current law and alternative schemes. Journal of post Keynesian economics, v. 8, fall 1985: 28-46.
"With the passage of the Social Security Amendments of 1983, benefits from the Old-Age, Survivors, and Disability Insurance (OASDI) program for the first time became subject to the personal income tax. Congress chose to tax Social Security benefits in a manner similar to the tax treatment of Unemployment Insurance (UI) benefits . . . . In this paper the authors explore the distributional impacts of the new taxing provision."

Smith, Ephraim P. Rozen, Etzmun S.
The effects of the Tax Reform Act of 1986 on pension plans. Tax executive, v. 39, spring 1987: 257-266.
"This article has focused on the major changes affecting retirement plans. The new law significantly changed: 1. Dollar limits to contributions to 401(k) plans; 2. Qualification rules for IRAs; 3. Penalty taxes on early withdrawals; 4. Limits of defined benefit plans; 5. Limits of defined contribution plans; 6. Vesting, participation and coverage rules."

Streer, Paul J. Barrack, John B.
The taxation of social security and railroad retirement benefits: statutory application and planning alternatives. Tax adviser, v. 15, Mar. 1984: 130-136.
"Illustrates the application of the new rules, discusses the important tax policy issues raised by the provisions and offers some planning suggestions to mitigate their impact."
House bill (H.R. 3838).

The Tax revolution: a new era begins. Tax notes, v. 32, Sept. 29, 1986: 1277-1304.
Provides a general description and analysis of the provisions of the Tax Reform Act of 1986.
Partial contents.--Individual taxation.--Tax shelters and real estate.--Retirement savings and qualified plans.

Taxing the family. Washington, American Enterprise Institute for Public Policy Research, 1983. 174 p. (AEI symposia 83A)
Partial contents.--Estate gift duty and the family: prolegomena to a theory of the family unit.--Social security and the family.

U.S. Congress. Conference Committees, 1986.
Tax Reform Act of 1986; conference report to accompany H.R. 3838. Washington, G.P.O., 1986. 2 v. (925, 886 p.) (Report, House, 99th Congress, 2nd session, no. 99-841)

U.S. Congress. House. Committee on Education and Labor.
Retirement Equity Technical Corrections Act of 1986; report together with additional views to accompany H.R. 2110 . . . including cost estimate of the Congressional Budget Office. Washington, G.P.O., 1986. 58 p. (Report, House, 99th Congress, 2nd session, no. 99-526,part 2)

U.S. Congress. House. Committee on Ways and Means.
Comprehensive tax reform. Hearings, 99th Congress, 1st session. Washington, G.P.O., 1986. 3693-4701 p.
"Serial 99-45"
Part 5 of 9: Impact on real estate and housing and on employee benefits and compensation.

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security.
Retirement income security in the United States. Hearings, before the Subcommittee on Social Security and the Subcommittee on Oversight of the Committee on Ways and Means, House of Representatives, 99th Congress, 1st session. Washington, G.P.O., 1986. 927 p.
"Serial 99-50"
Hearings held on July 18; September 5 and 6, 1985.

U.S. Congress. House. Select Committee on Aging.
1987 Federal income tax guide for older Americans: information for filing 1986 returns. Rev. ed., 99th Congress, 2nd session. Washington, G.P.O., 1987. 18 p.
At head of title: Committee print.
"Comm. pub. no. 99-603"

Taxes, social security, and the deficit. Hearing, 99th Congress, 1st session. Apr. 15, 1985. Washington, G.P.O., 1985. 122 p.
"Comm. pub. no. 99-505"

U.S. Congress. Joint Committee on Taxation.
General explanation of the Tax Reform Act of 1986 (H.R. 3838, 98th Congress; Public Law 99-514). Washington, G.P.O., 1987. 1379 p.
At head of title: Joint committee print.

U.S. Congress. Senate. Committee on Banking, Housing, and Urban Affairs.
Implications of H.R. 3838, the Tax Reform Act. Hearings, 99th Congress, 2nd session. Feb. 4, 5, and 6, 1986. Washington, G.P.O., 1986. 962 p. (Hearings, Senate, 99th Congress, 2nd session, S. Hrg. 99-557)

U.S. Congress. Senate. Committee on Finance.
Tax reform proposals--XIII. Hearing, 99th Congress, 1st session. July 11, 1985. Washington, G.P.O., 1986. 184 p. (Hearing, Senate, 99th Congress, 1st session, S. Hrg. 99-246, pt. XIII)
Hearing on tax reform proposals, focusing on the debate on alternative retirement arrangements.

U.S. Congress. Senate. Committee on Finance. Subcommittee on Savings, Pensions, and Investment Policy.
Retiree health benefits. Hearing, 99th Congress, 1st session. Sept. 9, 1985. Washington, G.P.O., 1986. 167 p. (Hearing, Senate, 99th Congress, 1st session, S. Hrg. 99-405)

U.S. Congress. Senate. Special Committee on Aging.
Helping older Americans to avoid overpayment of income taxes (deductions you are entitled to use for 1986); an information paper. Washington, G.P.O., 1987. 16 p. (Print, Senate, 100th Congress, 1st session, committee print S. Prt. 100-5)

U.S. President (1981- : Reagan)
The President's tax proposals to the Congress for fairness, growth, and simplicity. Washington, G.P.O., 1985. 461 p.
Partila contents.--Increase fairness for families.--Make the system more neutral and fair.--Reduce recordkeeping and complexity.--Simplify the system of filing.--Revise treatment of retirement savings.

PENSIONS AND RETIREE BENEFITS

Andrews, Emily S.
The changing profile of pensions in America. Washington, Employee Benefit Research Institute, 1985. 234 p. (EBRI-ERF policy study)
Partial contents.--Overview of the retirement income system.--Trends in employment-based pensions.--The railroad retirement system.--The civil service retirement system.--State and local government pensions plans.--The social security system.--The distribution of employer-sponsored pension coverage.--Workers without coverage and individual retirement saving options.--Pension coverage, industry growth and the business cycle.--Income and assets of the aging population.--The impact of the Retirement Equity Act.

Bell, Donald. Marclay, William.
Trends in retirement eligibility and pension benefits, 1974-83. Monthly labor review, v. 110, Apr. 1987: 18-25.
"Although annuity increase benefited retirees at all ages studied, the rate of increase was greater for those retiring at age 55 and 62, than at 65."

Bodie, Zvi.
Financial aspects of the United States pension system. Edited by Zvi Bodie and John B. Shoven. Chicago, University of Chicago Press, 1983. 452 p.
"A National Bureau of Economic Research Project Report"

Chandler, Rod.
Pursuing funding for retiree benefits. Business and health, v. 5, Dec. 1987: 21, 24-25.
"One approach to prefunding advocated by the business and insurance communities would be Voluntary Employee Beneficiary Associations . . . . Because the potential of VEBAs to funtion as an adequate funding mechanism remains limited, it is important to consider an alternative: the recently proposed Retiree Health Protection Act of 1987."

COBRA [Consolidated Omnibus Budget Reconciliation Act of 1985]. Business and health, v. 5, Dec. 1987: 4-6, 8-11.
Contents.--What does COBRA portend for the future, by Phyllis Borzi.--An employer's assessment of continuation coverage, by Mari Fulginiti.----COBRA requirements threaten small business coverage, by Frank Swain.

Doran, Phyllis A. MacBain, Kenneth D. Reimert, William A.
Measuring and funding corporate liabilities for retiree health benefits. Washington, Employee Benefit Research Institute, 1987. 226 p. (EBRI-ERF policy study)
"The growing awareness of these retiree medical benefits, the current deliberations of FASB [Financial Accounting Standards Board], and the uncertain legal climate surrounding postretirement medical plans are now leading many companies to take a closer look at their current programs."

Douglas, Drew.
The pension system: can its promises be kept? Congressional Quarterly weekly report, v. 45, Apr. 11, 1987: 647-652.
"Despite amendments enacted last year, the nation's 13-year-old pension protection law, the Employee Retirement Income Security Act (ERISA), remains riddled with loopholes . . . . Calls to plug the holes are growing louder, spurred by the desperation of workers from the troubled U.S. steel industry and by the soaring deficits of the Pension Benefit Guaranty Corp. (PBGC), the federal agency that insures most private pension plans in the United States." Examines the Reagan administration proposal to overhaul ERISA and shore up the PBGC.

EBRI quarterly pension investment report. Washington, Employee Benefit Research Institute, 1986. 125 p.
First issue of a quarterly publication which results from a joint, ongoing project between EBRI and the Federal Reserve Board.
Partial contents.--Quarterly funding and investing of private trusteed plans (1982-1986).--Earnings of private trusteed plans (1982-1986).--Quarterly asset structure of private trusteed plans

(1982-1986).--Annual asset structure of private and public pension plans (1950-1985).--Pension assets and the economy (1950-1985).--Legislative and regulatory issues.--Data sources and tabulation methods.

Economic incentives for retirement in the public and private sectors. EBRI issue brief, no. 57, Aug. 1986: whole issue (15 p.)
"Indicates current legislative interest in increasing work among the elderly through changes in Social Security provisions and tax reform. The impact of the proposed abolition of mandatory retirement is also examined. Projections of labor force participation and compensation are reviewed to determined whether forecasting models anticipate any future changes in the pattern of retirement. Costs not incorporated in forecasting models that may influence employer-sponsored programs are also discussed, including greater-than-anticipated increases in longevity which could eventually lead to changes in pension plan provisions."

Employee benefits and the 1987 Reagan budget. EBRI issue brief, no. 53, Apr. 1986: 1-17.
"Analyzes the potential impact of Gramm-Rudman-Hollings and the president's budget proposals on employee benefits." Focus is on retirement, disability, and unemployment programs, and health and safety programs.

Fundamentals of employee benefit programs. 3rd ed. Washington, Employee Benefit Research Institute, c1987. 304 p.

Goeppinger, Kathleen H.
Postemployment welfare benefit plans: an emerging priority of the '80s. Employee benefits journal, v. 12, Mar. 1987: 32-36.
"Reviews the historical background of postemployment welfare plans, current legal, legislative and planning issues, and proactive steps companies can take to manage these benefits." Retiree welfare plans vary but may include such coverage as "comprehensive medical, Medicare fill-in, prescription drugs, private duty nursing, hospice or nursing home care and dental" benefits.

Grosskopf, Shawna. Hayes, Kathy. Kennedy, Thomas.
Supply and demand effects of underfunding of pensions on public employee wages. Southern economic journal, v. 51, Jan. 1985: 745-753.
Investigates "the need for state regulation of local government pension plans" because of underfunding. Finds that underfunding municipal police pension plans in Illinois "does significantly increase the demand for police services by local governments."

Grubbs, Donald S., Jr.
The Employee Retirement Income Security Act: the first decade. Journal of pension planning and compliance, v. 11, spring 1985: 7-47.
Addresses the questions: "What are the continuing policy issues facing pension plans today? and What are the possible solutions?" Concludes that "every issue that affects employment, inflation, investment returns, or life expectancy--from cyclical downturns in the economy to the total disruption of nuclear war--has a major impact upon pension plans. The pension issues to be addressed in the years ahead are considerably broader than those for which solutions have already been reached."

Horlick, Max.
The relationships between public and private pension schemes: an introductory overview. Social security bulletin, v. 50, July 1987: 15-24.
Presents trends in social insurance and private pensions since 1970. "The current debate centers on which public-private pension mix is desirable from the point of view of an old-age income-maintenance program. A new element is the rising support for a 'third pillar'--individual tax-encouraged savings--not only as a supplement, but as an alternative to social insurance."

Impact of Retirement Equity Act. EBRI issue brief, no. 39, Feb. 1985: 1-11.
"Estimates numbers of new pension plan participants and vested workers that result from the new 1984 legislation, using simulations for employed workers in 1983 and bringing these estimates forward to 1985. It gives illustrative ranges of first-year plan costs for its key provisions."

Ippolito, Richard A.
The economic function of underfunded pension plans. Journal of law and economics, v. 28, Oct. 1985: 611-651.

Article develops a theory of underfunded pension plans and finds that the "underfunding of the pension plan serves as a bond of sorts: it imposes automatic and (calculably) large capital losses on union workers who precipitate a successful holdup. The theory appears to explain the long-standing puzzle that firms underfund their pension plans despite heavy tax consequences. In addition, by identifying the beneficiaries of federal pension insurance, the theory also leads to a natural explanation for the enactment in 1974 of the Employee Retirement Income Security Act (ERISA)."

Pension security: has ERISA had any effect? Regulation, v. 11, no. 2, 1987: 15-22.

"ERISA appears to provide a classic regulatory problem. The legislation was ostensibly enacted to reduce fraud in pension contracts--and thereby improve the security of private pensions--yet there is no evidence that fraud was an important problem . . . . What the regulations succeed in doing is transferring billions of dollars from the majority of workers to a favored few in failing firms. These transfers and the tax scheme to pay for them have created potentially serious economic distortions that were not present prior to ERISA."

Kosterlitz, Julie.

Promises to keep. National journal, v. 19, Aug. 29, 1987: 2138-2144.

Looks at the nation's private pension system, its gaps in coverage, the Pension Benefit Guaranty Corporation, and related risks for the nation's economy.

Markman, Steven.

Once and future retirement. Across the Board, v. 22, May 1985: 40-50.

"We're in a time of pension and retirement reform. A flurry of legislation in Congress may force companies to reassess their policies. If Congress doesn't do it, the realities of an aging work force eventually will."

Melbinger, Michael S.

Retiree medical benefit plans and the impact of the bankruptcy filing of LTV Corp. Employee relations law journal, v. 12, spring 1987: 641-662.

"The critical level of unfunded retiree medical liability faced by many companies was brought to prominence when LTV Corp., the nation's second largest steel producer, filed for bankruptcy reorganization and promptly terminated its retiree medical benefit plan."

Merton, Robert C. Bodie, Zvi. Marcus, Alan J.

Pension plan integration as insurance against social security risk. Cambridge, Mass., National Bureau of Economic Research, 1984. 35 p. (Working paper no. 1370)

Focuses on pension plan integration's affect on "the alteration of the risk-bearing relationships between employees, employers and the government vis-a-vis social security benefits. The main alteration is that the employer in effect insures his covered employees against adverse changes in their social security retirement benefit."

Merz, Stuart O. H.

Retiree benefits: are they guaranteed for life? Employee relations law journal, v. 11, spring 1986: 619-634.

"The acceleration of plant closings in the past several years and the unprecedented escalation in the cost of health care have made non-pension benefits for retirees a major topic of concern. This combination of circumstances has resulted in steadily increasing health-care costs for a significantly older group of persons, with no productive work force over which to spread the risk or to provide revenues to help cover those costs." This Article examines Federal appellate cases.

Pension portability and benefit adequacy. EBRI issue brief, no. 56, July 1986: whole issue (15 p.)

"Portability--the worker's ability to retain pension rights when changing employers--can have a sizable impact on the adequacy of one's retirement income. Incomplete portability may decrease replacement rates, i.e., the ratio of retirement income to preretirement income. In general, the more jobs held and the steeper the earnings growth, the lower the eventual replacement rate. To encourage greater retirement income security for future retirees, Congress is currently considering legislation that would affect all aspects of portability.

Pension portability and what it can do for retirement income: a simulation approach. Washington, Employee Benefit Research Institute, 1987. 19 p. (EBRI issue brief no. 65)

"A simulation model using four employees and assigning different age, job, and pension plan factors was used to construct examples of the economic consequences of pension portability. For defined benefit plans, the simulation indicated that a cash out of benefits and their reinvestment by the former participant at an interest rate of one percentage point higher than that of the plan would not significantly increase eventual pension benefits."

Pension vesting standards: ERISA and beyond. EBRI issue brief, no. 51, Feb. 1986: whole issue (16 p.)

"Reviews vesting standards under ERISA Employee Retirement Income Security Act and provides information on the distribution of actual vesting provisions used by plans since ERISA was enacted. The vesting rate among plan participants is tracked before and after ERISA to evaluate whether more workers are likely to be entitled to benefits at retirement. The relationships between age, on-the-job tenure, and plan vesting provisions are also reviewed. The use of preretirement lump-sum distributions is discussed in that context."

Pratt, Jennifer L.

Reversion of surplus pension assets upon plan termination: is it consistent with the purpose of ERISA? Indiana law journal, v. 62, no. 3, 1986-1987: 805-825.

"This Note discusses the determination of the legal status of surplus pension assets upon termination of Defined Benefit Plans. It begins by tracing the evolution of the theories behind private pension plans. It next examines the arguments for and against allowing reversion. The Note concludes by suggesting possible solutions to apparent conflicts between the original purpose of ERISA and judicial policy."

Rovner, Julie.

New Federal retirement plan wins approval from Congress. Congressional Quarterly weekly report, v. 44, May 24, 1986: 1201-1203.

Reviews some of the provisions of HR 2672 which sets up a "three-tiered" Federal retirement system. "The new plan consists of three major parts: Social Security, a required basic plan to supplement Social Security and an optional tax-deferred savings plan similar to private 401(k) plans."

Sahin, Izzat.

Job mobility and private pensions. Brookfield, Wis., International Foundation of Employee Benefit Plans, c1986. 49 p. (Research report no. 86-2)

Schleck, Robert W.

Reforming Federal pension programs. In Control of Federal spending. Edited by C. Lowell Harriss. New York, Academy of Political Science, 1985. (Proceedings, v. 35, no. 4, 1985) p. 85-100.

Reviews the findings of the Grace Commission concerning the operations of the Civil Service Retirement System, the Military Retirement System, and the Foreign Service Retirement System. "The Grace Commission concluded that the CSRS, MRS, and FSRS grant benefits and sustain costs three to six times greater than the most generous private-sector retirement plans."

Schulz, James H. Leavitt, Thomas D.

Pension integration: concepts, issues, and proposals. Washington, Employee Benefit Research Institute, c1983. 83 p.

Shipp, P. Royal.

Comparing costs and benefits of the civil service retirement system to private sector and State government systems. Congressional Research Service review, v. 6, Mar. 1985: 16-17, 24-25.

"Costs and benefits of the current Civil Service Retirement System (CSRS) continue to generate political controversy . . . . Congressional concern over these costs and benefits, and how they compare to private sector and State government experience will manifest itself in the 99th Congress as debates proceed over ways to reduce the Federal budget deficit and over options for designing a new Federal retirement system for Federal workers covered by social security."

Smith, Ephraim P. Rozen, Etzmun S.
The effects of the Tax Reform Act of 1986 on pension plans. Tax executive, v. 39, spring 1987: 257-266.
"This article has focused on the major changes affecting retirement plans. The new law significantly changed: 1. Dollar limits to contributions to 401(k) plans; 2. Qualification rules for IRAs; 3. Penalty taxes on early withdrawals; 4. Limits of defined benefit plans; 5. Limits of defined contribution plans; 6. Vesting, participation and coverage rules."

10th anniversary of the Employee Retirement Income Security Act of 1974; a report of conference proceedings, Special Committee on Aging, Sept. 11, 1984. Washington, G.P.O., 1985. 89 p. (Print, Senate, 98th Congress, 2nd session, committee print S. Prt. 98-290)

U.S. Congress. Conference Committees, 1986.
Federal Employees' Retirement System Act of 1986; conference report to accompany H.R. 2672. Washington, G.P.O., 1986. 160 p. (Report, Senate, 99th Congress, 2nd session, no. 99-302)

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Labor-Management Relations.
Legislative hearing on H.R. 2811, 2812, and 2813, bills related to the single-employer pension plan termination insurance system. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1986. 271 p.
"H.R. 2811, 2812, and 2813 to amend the Employee Retirement Income Security Act of 1974."
"Hearing held in Washington, DC, July 16, 1985."
"Serial no. 99-37"

Oversight hearing on the Employee Retirement Income Security Act: requiring pension accruals for work beyond normal retirement age. Hearing, 98th Congress, 2nd session. Sept. 5, 1984. Washington, G.P.O., 1985. 144 p.

Oversight hearings on employee benefit plans. Hearings, 99th Congress, 1st session. Washington, G.P.O., 1986. 876 p.
"Serial no. 99-114"
Hearing before the full committee held in Washington, DC, Mar. 21, 1985 and hearings before the Subcommittee on Labor-Management Relations held in Washington, DC, Apr. 2 and 3, 1985.

"Pension losers." Hearing, 98th Congress, 2nd session, H.R. 3218. Sept. 20, 1984. Washington, G.P.O., 1985. 200 p.

The Pension Portability Act of 1987. Hearing, 100th Congress, 1st session on H.R. 1961 and H.R. 1962. Apr. 21, 1987. Washington, G.P.O., 1988. 294 p.
"Serial no. 100-55"

The Retirement Income Policy Act of 1985 and the Retirement Universal Security Arrangements Act of 1986. Hearing, 99th Congress, 2nd session on H.R. 3098 and H.R. 3594. Feb. 25, 1986. Washington, G.P.O., 1986. 578 p.
"Serial no. 99-133"

U.S. Congress. House. Committee on Post Office and Civil Service.
Federal Employees' Retirement System Act of 1986. Washington, G.P.O., 1986. 159 p.
At head of title: 99th Congress, 2nd session. Committee print 99-8.

U.S. Congress. House. Committee on Post Office and Civil Service. Subcommittee on Compensation and Employee Benefits.
Fiscal 1987 budget concerning pay, retirement, and health benefits, and H.R. 4060. Hearing, 99th Congress, 2nd session. Feb. 20, 1986. Washington, G.P.O., 1986. 210 p.
"Serial no. 99-44"

U.S. Congress. House. Committee on the Judiciary. Subcommittee on Monopolies and Commercial Law.
Retiree benefits in bankruptcy. Oversight hearing, 99th Congress, 2nd session on H.R. 5283 and related bills. Aug. 7, 1986. Washington, G.P.O., 1987. 189 p.
"Serial no. 113"

U.S. Congress. House. Committee on Ways and Means.
Economic Equity Act and related tax and pension reform. Hearing, 98th Congress, 1st session. Oct. 25, 1983. Washington, G.P.O., 1984. 212 p.
"Serial 98-51"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Oversight.
PBGC proposal to initiate a variable rate premium system; and public comments on Administration's pension plan funding and premium rate proposals. Hearings, 100th Congress, 1st session. Apr. 7 and 9, 1987. Washington, G.P.O., 1988. 438 p.
"Serial 100-23"
Includes a reprint of the GAO's Mar. 1987 report titled, "Pension plans: government insurance program threatened by its growing deficit."

Proposals in the President's competitiveness initiative that affect funding and termination of defined benefit pension plans. Hearing, 100th Congress, 1st session. Mar. 6, 1987. Washington, G.P.O., 1987. 100 p.
"Serial 100-16"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Social Security.
Retirement income security in the United States. Hearings, before the Subcommittee on Social Security and the Subcommittee on Oversight of the Committee on Ways and Means, House of Representatives, 99th Congress, 1st session. Washington, G.P.O., 1986. 927 p.
"Serial 99-50"
Hearings held on July 18; September 5 and 6, 1985.

U.S. Congress. House. Select Committee on Aging.
Financing retiree health benefits: health security for retirees. Hearing, 100th Congress, 1st session. June 24, 1987. Washington, G.P.O., 1987. 111 p.
"Comm. pub. no. 100-652"

Overfunded pension plans. Joint hearing before the Select Committee on Aging and the Subcommittee on Labor-Management Relations of the Committee on Education and Labor, House of Representatives, 99th Congress, 1st session. June 12, 1985. Washington, G.P.O., 1985. 453 p.
"Select Committee on Aging Ser. no. 99-520"
"Subcommittee on Labor-Management Relations Ser. no. 99-10"

Pension plans: many workers don't know when they can retire. Hearing, 100th Congress, 1st session. Sept. 23, 1987. Washington, G.P.O. 1988. 107 p.
"Comm. pub. no. 100-649"

Protection of retiree benefits legislation: minimum funding standards and variable rate premiums. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1988. 80 p.
Hearing held May 1, 1987 in Dundalk, Md.
"Comm. pub. no. 100-643"

U.S. Congress. Joint Committee on Taxation.
Overview of current issues relating to single-employer defined benefit pension plans and Pension Benefit Guaranty Corporation (PBGC) premiums scheduled for hearings before the Subcommittee on Oversight of the Committee on Ways and Means on April 7 and 9, 1987. Washington, G.P.O., 1987. 49 p.
At head of title: Joint committee print.

U.S. Congress. Senate. Committee on Finance. Subcommittee on Savings, Pensions, and Investment Policy.
Retirement Income Policy Act. Hearing, 99th Congress, 2nd session on S. 1784. Jan. 28, 1986. Washington, G.P.O., 1986. 607 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-671)

U.S. Congress. Senate. Committee on Governmental Affairs.
Civil Service Pension Reform Act of 1985. Hearing, 99th Congress, 1st session on S. 1527. Washington, G.P.O., 1986. 981 p. (Hearing, Senate, 99th Congress, 1st session, S. Hrg. 99-754)
Hearings held Sept. 9, 10, and 11, 1985.

Supplemental information regarding the Federal Employees' Retirement System Act of 1986; report. Washington, G.P.O., 1986. 161 p. (Print, Senate, 99th Congress, 2nd session, committee print S. Prt. 99-184)

U.S. Congress. Senate. Committee on Governmental Affairs. Subcommittee on Oversight of Government Management.
The Department of Labor's enforcement of the Employee Retirement Income Security Act (ERISA); report. Washington, G.P.O., 1986. 71 p. (Print, Senate, 99th Congress, 2nd session, S. Prt. 99-144)

U.S. Congress. Senate. Committee on Labor and Human Resources. Subcommittee on Aging.
Older Americans Pension Benefit Act. Hearing, 99th Congress, 1st session on S. 1427. Oct. 17, 1985. Washington, G.P.O., 1986. 138 p. (Hearing, Senate, 99th Congress, 1st session, S. Hrg. 99-466)
"To prohibit the suspension of an employee's benefit accrued under a retirement plan solely because of age before accruing the maximum normal retirement benefit."

U.S. Congress. Senate. Committee on Labor and Human Resources. Subcommittee on Labor.
Overfunding and underfunding of pension plans. Joint hearing before the Subcommittee on Labor of the Committee on Labor and Human Resources, United States Senate and the Subcommittee on Labor-Management Relations of the Committee on Education and Labor, House of Representatives, 100th Congress, 1st session. Mar. 24, 1987. Washington, G.P.O., 1988. 353 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-431)

U.S. General Accounting Office.
Analysis of Grace Commission proposals to change the civil service retirement system; report to the chairman, Committee on Post Office and Civil Service, House of Representatives. Feb. 13, 1985. Washington, G.A.O., 1985. 14 p.
"GAO/GGD-85-31"
Agrees with the Commission that private sector practices are a standard for evaluating the Federal program and that many of the Commission's recommendations reflect common private system features. However, because the Grace proposals lack a capital accumulation plan, unlike many private plans, Federal benefits would be lower than typical private benefits. "Moreover, for many of the recommendations, the Commission overstated the level of savings that could be acheived."

The 1980 Multiemployer Pension Plan Amendments Act: an assessment of funding requirement changes. Feb. 27, 1985. Washington, G.A.O., 1985. 75 p.
"GAO/HRD-85-1"
"The Multiemployer Pension Plan Amendments Act of 1980 changed funding provisions to improve plan financing because of concern that the plans could place large claims on the insurance program. GAO found that the provisions would generally have little effect on plan financial condition or employers contributing to the plans . . . . Because of the potential risk distressed plans pose to the program, GAO asks the Congress to consider changing the provisions so that the plans will be required to at least maintain contributions more in line with what employers already contribute."

Pension integration: how large defined benefit plans coordinate benefits with social security; briefing report to congressional requesters. July 1986. Washington, G.A.O., 1986. 28 p.
"GAO/HRD-86-118BR"

"In integrated plans, higher paid workers get a pension benefit that replaces a greater share of their final earnings than lower paid workers, thus countering the tilt in Social Security benefits toward low earners . . . . In this briefing report, GAO estimates the maximum proportions of large defined benefit plans and their participants that might be affected by the proposed changes in the integration rules."

Pension plans: many workers don't know when they can retire; briefing report to the chairman, Select Committee on Aging, House of Representatives. Aug. 12, 1987. Washington, G.A.O., 1987. 36 p.
"GAO/HRD-87-94BR, B-222718"
"Used information from the 1983 Survey of Consumer Finances to estimate the number and characteristics of workers in defined benefit pension plans nationwide who knew (1) if they would be eligible for early retirement and (2) when they would first be eligible for full retirement benefits (normal retirement) or reduced retirement benefits (early retirement)."

Pensions: plans with unfunded benefits; briefing report to the Chairman, Subcommittee on Oversight, Committee on Ways and Means, House of Representatives. Oct. 1986. Washington, G.A.O., 1986. 23 p.
"GAO/HRD-87-15BR"
Assesses "the extent of and changes in unfunded benefits in ongoing defined benefit plans." GAO concludes that "the contingent liability to the Pension Benefit Guaranty Corporation's insurance program is significant and growing. Considering the insurance fund's current deficit, GAO believes that the program could be in jeopardy if the recent trend in the termination of plans with large amounts of unfunded benefits continues."

Railroad retirement: Federal financial involvement; report to the Chairman, Committee on the Budget, United States Senate. May 1986. Washington, G.A.O., 1986. 59 p.
"GAO/HRD-86-88"
Presents "an inventory and description of past and present federal financial assistance to the rail industry's retirement and unemployment programs administered by the Railroad Retirement Board and shows how much assistance will be needed under current law to continue the federal government's unique relationship with these programs." GAO found that "Federal financial involvement in the railroad retirement program has increased to where it now comprises almost half of annual revenues. Almost 85 percent of this involvement has come from an annual transfer of funds from social security;" and other costs involve direct payments from general revenues, and "special treatment regarding taxation of benefits, tax revenues, investment authority, and certain administrative expenses."

Retirement before age 65: trends, costs, and national issues; report to the Chairman, Select Committee on Aging, House of Representatives. July 1986. Washington, G.A.O., 1986. 73 p.
"GAO/HRD-86-86"
"Documents the trend toward earlier receipt of employer-sponsored pensions, shows that most pension recipients do not take other jobs, and estimates both Social Security and income tax revenue losses due to voluntary early retirement. The report also discusses some of the issues involved in the early retirement trend and some of the legislative proposals to reduce incentives for early retirement and reduce obstacles to older worker employment."

Vavrichek, Bruce.
Federal insurance of private pension benefits. Washington, U.S. Congressional Budget Office, for sale by the Supt. of Docs., G.P.O., 1987. 59 p.
Contents.--Introduction.--The structure of private pensions.--Federal insurance of benefits in single-employer defined-benefit pension plans. --The financial status of the PBGC.--Current issues and policy alternatives.

Vogel, Joan.
Until death do us part: vesting of retiree insurance. Industrial relations law journal, v. 9, no. 2, 1987: 183-241.
"While the passage of the Employee Retirement Income Security Act ('ERISA') established assurances that promised pension benefits would be received by retirees, similar protections do not exist with respect to

retirees' medical and health insurance benefits. The author notes that in fact many employers have reduced or eliminated insurance benefits promised to retirees. Discusses the development of case law, both prior to and following the passage of ERISA, which does provide some protections for retired employee insurance recipients and explores disclosure requirements and fiduciary liability imposed by ERISA. Concludes that further protections are in order and advocates amendments to ERISA which would require similar standards for retiree medical and life insurance benefits as exist for pension benefits."

Women, families and pensions. EBRI issue brief, no. 49, Dec. 1985: 1-11.
"Evaluates trends in pension coverage, participation and benefit entitlement among women along with trends in women's labor market activity."

HOME AS ASSET

Chen, Alexander.
Alternative reverse mortgages: a simulation analysis of initial benefits in Baltimore. Housing finance review, v. 2, Oct. 1983: 295-308.
Simulate "the effect on initial income of four alternative reverse mortgages had they been available to elderly homeowners living in the Baltimore Standard Metropolitan Statistical Area." The reverse mortgage is an arrangement whereby the homeowner mortgages the present accumulated home equity in order to obtain a stream of payouts from the lender.

The Future is Now: a Home Equity Conversion Conference (1985: Washington, D.C.)
Proceedings from The Future is Now, A Home Equity Conversion Conference. Washington, U.S. Administration on Aging: U.S. Dept. of Housing and Urban Development, Office of Intergovernmental Relations, [1985?] 76 p.

Garnett, Robert. Guttentag, Jack M.
The reverse-shared-appreciation mortgage. Housing finance review, v. 3, Jan. 1984: 63-84.
Model and evaluate "the reverse-shared-appreciation mortgage (RSAM), a new approach to home equity conversion." Describe the basic characteristics of the individual RSAM. Develop a cash-flow model: to evaluate how annuity amounts are determined; to assess the riskiness of lending to the pool; and to assess the risk to homeowners participating in RSAMs of hyper-inflation and default.

Guttentag, Jack M.
Reverse annuity mortgages: how S&L's can write them. Federal Home Loan Bank Board journal, v. 10, July 1977: 18-23.
Explains techniques of writing reverse annuity mortgages, "a means by which a household may convert the equity in its home into a stream of income, or into a single lumpsum payment, with the owner retaining the right to live in the house until death without any repayment obligation during his or her life."

Harris, Jack.
Tapping home equity: a cause for concern? Mortgage banking, v. 46, June 1986: 32, 35, 37-38, 40, 42.
"Today, a viable credit market for second mortgages makes the home a more liquid investment and may provide a more affordable alternative to unsecured personal debt. Will the homeowner be the next to join the line of debtors? The growing popularity of home equity access programs is merely another way for individuals to sacrifice future financial security, according to this article."

Hoeflich, M. H.
Housing the elderly in a changing America: innovation through private sector initiative. University of Illinois law review, v. 1985, no. 1, 1985: 1-38.
Article "outlines the current and past thrust of governmental activities, at both the federal and state levels, designed to provide housing aid to the elderly, and shows that much of this governmental effort has ignored elderly homeowners. Because of this governmental oversight, this article considers the increasingly large group of elderly homeowners who wish to retain some equity interest either in their present housing or in new housing, and sketches innovative ways in which the private sector, without direct government subsidy or intervention, can provide economically rational solutions to the problems of elderly homeownership."

Home equity conversion: should your home pay for your home care? Caring, v. 4, June 1985: 36-39, 41.
Explains the use of home equity conversion plans, such as reverse annuity mortgages, split equity and sale/leaseback arrangements or deferred payment loans, to assist older homeowners willing to take the risk.

House rich, but cash poor: home equity conversion options for older homeowners. Washington, Federal Council on the Aging, 1983. 85 p.
Contains the presentations of a fact-finding session of the housing committee of the Federal Council on the Aging concerning the tax aspects of sale/leaseback transactions. Discusses proposed legislation which will open up home equity option for older homeowners.

Jacobs, Bruce. Weissert, William.
Using home equity to finance long-term care. Journal of health politics, policy and law, v. 12, spring 1987: 77-95.
"Analyzes the potential of using home equity to finance long-term care of the elderly, including payments for home care and for long-term care insurance . . . . First estimates each homeowner's risk of need for care (and risk of institutionalization) and then calculates the degree to which home equity could be used to cover the costs of home care (or of insurance premiums)."

Kenny, Kathleen. Belling, Bronwyn.
Home equity conversion: a counseling model. Gerontologist, v. 27, Feb. 1987: 9-12.
"Many older Americans now find themselves 'house rich but cash poor.' One solution to this predicament was developed by a nonprofit California organization. Described is a home equity conversion counseling model in partnership with private sector resources. Obstacles to widespread acceptance of this concept are discussed, as well as future policy implications."

U.S. Congress. House. Select Committee on Aging. Subcommittee on Housing and Consumer Interests.
Home equity conversion. Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 58 p.
"Comm. pub. no. 98-426"
Hearings held Oct. 22, 1983, Mattydale, N.Y.

Home equity conversion: issues and options for the elderly homeowner; a joint briefing by the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging, House of Representatives and the Special Committee on Aging, United States Senate, 99th Congress, 1st session. Washington, G.P.O., 1985. 97 p.
At head of title: Committee print.
"House Aging pub. no. 99-513"

U.S. Congress. Senate. Special Committee on Aging.
Opportunities in home equity conversion for the elderly. Hearing, 97th Congress, 2nd session. July 20, 1982. Washington, G.P.O., 1983. 63 p.

Turning home equity into income for older homeowners. Washington, G.P.O., 1984. 15 p. (Print, Senate, 98th Congress, 2nd session, committee print S. Prt. 98-216)

PERSONAL SAVINGS AND RETIREMENT PLANNING

Bernheim, B. Douglas.
Dissaving after retirement: testing the pure life cycle hypothesis. Cambridge, Mass., National Bureau of Economic Research, 1984. 63 p. (Working paper no. 1409)
"We argue that existing evidence on bequeathable age-wealth profiles is suspect, and provide new evidence based on longitudinal data indicating that significant dissaving may occur, particularly among single individuals and early retirees. We argue that, in the presence of annuities, estimates of dissaving should be adjusted by including the simple discounted value of

benefits in total wealth . . . . We test the pure life cycle hypothesis by observing the behavioral response of rates of accumulation to involuntary annuitization, and find empirical refutation of life cycle implications."

Boskin, Michael J.
Future social security financing alternatives and national saving. Cambridge, Mass., National Bureau of Economic Research, 1987. 30, 27 p. (Working paper no. 2256)
"OASDI is projected to accrue a very large surplus over the next thirty years, peaking at almost 30% of GNP . . . . These alternatives may affect net national saving, directly because Social Security surpluses or deficits are part of government sector saving and indirectly through effects on private saving or the non-Social Security part of the federal government budget. This paper documents how various systematic deviations from, or return to, pay-as-you-go finance of the Social Security system may affect net national saving."

Burbidge, John B.
Social security and savings plans in overlapping-generations models. Journal of public economics, v. 21, June 1983: 79-92.
"Examines the impact of social security and saving plans on a simple overlapping generations model with no uncertainty . . . . Savings plans and pay-as-you-go social security are seen to have quite different effects depending on the assumptions governing the growth rates of public debt and capital, and it is also shown that the social security program proposed by Feldstein is infeasible in the steady state he adopts as a starting-point."

Cartwright, William S.
Saving, social security and private pensions. International social security review, v. 37, no. 2, 1984: 123-138.
Reports findings from inconclusive research on the effects of social security and pensions on national and personal savings levels in the U.S. and OECD countries.

Duncan, Greg J. Mitchell, Olivia S. Morgan, James N.
A framework for setting retirement savings goals. Journal of consumer affairs, v. 18, summer 1984: 22-46
"Develops a framework for calculating savings needed to meet retirement goals under a variety of alternative assumptions about the economic and institutional environment . . . . Takes into account the effects of inflation, the role of Individual Retirement Accounts (IRAs), and possible future changes in tax laws . . . . The goal is to evaluate how best to plan for a smooth, regular consumption level before and after retirement and to adjust savings programs for changes in one's situation or expectations."

Entitlements planning for elderly clients. Boston, Mass., Massachusetts Continuing Legal Education, 1985. 276 p.

Evans, Owen.
Social security and household saving in the United States: a re-examination. International Monetary Fund staff papers, v. 30, Sept. 1983: 601-618.
"Examines household saving and consumption behavior in the United States in the light of recent controversies about the impact of the social security system on the consumption/saving decision." Concludes that "when a possible specification error is corrected, the results appear to favor somewhat the existence of a significant depressing effect of social security wealth on household saving in the United States," and that "there is also some evidence that social security depresses household saving by redistributing income toward those income and age groups that have higher than average marginal propensities to consume, rather than through complex calculations of social security wealth."

Feldstein, Martin.
The optimal level of social security benefits. Quarterly journal of economics, v. 100, May 1985: 303-320.
"The optimal level of social security benefits depends on balancing the protection that these benefits offer to those who lack the foresight to provide for their own old age against the welfare costs of distorting economic behavior. The primary such cost is the distortion in private saving. The present paper derives the level of social security benefits that is optimal in three basic cases. In the first section the paper derives the optimal level of benefits for an economy in which all

individuals do not anticipate retirement at all and therefore do no saving. The second and third sections then derive optimal benefits for two different definitions of incomplete myopia."

The welfare cost of social security's impact on private saving. Cambridge, Mass., National Bureau of Economic Research, 1982. 16 p. (Working paper no. 969)

"Although there have been several studies of the effect of social security on private saving, there has been no attempt to measure the welfare cost of this distortion. The present paper develops an analytic framework for this evaluation and presents numerical calculations."

Ferrara, Peter J.
Intergenerational transfers and super IRA's. Cato journal, v. 6, spring-summer 1986: 195-228.

"Fundamental reform of Social Security must become a primary concern for market-oriented policymakers. This paper examines why the case for such reform should now have broad public appeal. It also advances a politically appealing reform approach that should have substantial prospects for success" and discusses the privatization of social security.

Friedman, Joseph. Sjogren, Jane.
Assets of the elderly as they retire. Social security bulletin, v. 44, Jan. 1981: 16-31.

"This study, using data from the Retirement History Study, indicates that as older Americans enter their retirement years, their property wealth is generally very limited and can seldom be expected to be much help in maintaining their preretirement standard of living . . . . Equity in the home is usually the most important form of asset for the elderly; liquid or income-producing assets are generally very limited in amount."

Hubbard, R. Glenn.
The financial impacts of social security: a study of effects on household wealth accumulation and allocation. New York, Graduate School of Business Administration, New York University, 1983. 48 p. (Monograph series in finance and economics, monograph 1983-3)

Partial contents.--Modeling the impact of social security on household saving.--Modeling the impact of social security on household portfolio allocation. Assessing the impact of a change in social security policy.

Personal taxation, pension wealth, and portfolio composition. Review of economics and statistics, v. 67, Feb. 1985: 53-60.

"This paper emphasizes the roles played by personal taxation and pension wealth in portfolio choice and composition. A theoretical discussion of the impacts of taxation and participation in social security and private pension systems on individual wealth allocation is followed by empirical evidence based on U.S. cross-section data. Both effects prove to be significant. Anticipated social security and private pension benefits exert a measurable influence on household portfolio allocation. Their omission from an asset demand model may lead to a misinterpretation of the impact of taxation on portfolio composition."

'Precautionary' saving revisited: social security, individual welfare, and the capital stock. Cambridge, Mass., National Bureau of Economic Research, 1984. 40 p. (Working paper no. 1430)

"This paper focuses on precautionary saving against uncertain longevity and on the annuity insurance aspects of social security within the life-cycle framework."

Uncertain lifetimes, pensions, and individual saving. Cambridge, Mass., National Bureau of Economic Research, 1984. 47 p. (Working paper no. 1363)

"The emphasis here is on the annuity insurance aspects of social security and pensions. A simple life-cycle model is put forth to show that even an actuarially fair, fully funded social security system can reduce individual saving by more than the tax paid. Hence, previous partial equilibrium estimates of the impact of social security on saving drawn solely from consideration of the intergenerational wealth transfer at the introduction of the system are, if anything too small."

Social security and individual welfare: precautionary saving, liquidity constraints and the payroll tax, by R. Glenn Hubbard and Kenneth L. Judd. Cambridge, Mass., National Bureau of Economic Research, 1985. 29, 8 p. (Working paper no. 1736)

Analyzes "the importance of capital-market imperfections (market failure in the private provision of annuities and borrowing restrictions) in describing the impact of social security on individual welfare and the capital stock . . . . Using simulation models under various assumptions about individual preferences and technology, analyzes the impact of precautionary saving against lifetime uncertainty and borrowing restrictions on individual welfare and the capital stock in the presence and absence of social security annuities."

Hymans, Saul H.
Saving, investment, and social security. National tax journal, v. 34, Mar. 1981: 1-8.

"Questions the analytical basis for the view that the Social Security System depresses the national saving rate. It is shown that an actuarial system is unlikely to lower the saving rate but that a pay-as-you-go system can either lower or raise the saving rate depending on whether there are, respectively, 'too many' or 'too few' workers relative to the number of retirees."

Individual retirement plans: individual retirement accounts, individual retirement annuities, simplified employee pensions. Chicago, Commerce Clearing House, c1986. 48 p.

"CCH editorial staff publication."

Kilty, Keith M. Behling, John H.
Retirement financial planning among professional workers. Gerontologist, v. 26, Oct. 1986: 525-530.

"This research examined the extent and patterns of financial planning among a range of professionals (lawyers, social workers, high school teachers, and college professors). The 457 respondents placed their primary emphasis on pensions (including Social Security) and continued work-related income, although four types of pre-retirement financial planning were identified. The most consistent predictor of the extent of planning was present income, but gender was also important. The extent of planning, however, was limited."

Kotlikoff, Laurence J. Spivak, Avia. Summers, Lawrence H.
The adequacy of savings. American economic review, v. 72, Dec. 1982: 1056-1069.

"This paper uses newly available data from the Social Security Administration's Retirement History Survey to examine the adequacy of saving . . . . The evidence indicates that surprisingly few couples currently suffer significant reductions in their standard of living in their old age. This appears due, in large part, to our compulsory savings institutions, the Social Security and private pension systems."

Leimer, Dean R. Lesnoy, Selig D.
Social security and private saving: new time-series evidence. Journal of political economy, v. 90, June 1982: 606-646.

Critique Martin Feldstein's contention that the introduction of social security reduced personal saving by 50 percent. Includes reply by Feldstein.

Lesnoy, Selig D. Leimer, Dean R.
Social security and private saving: theory and historical evidence. Social security bulletin, v. 48, Jan. 1985: 14-30.

Assesses the continuing debate over Martin Feldstein's and more recent evidence concerning the relationship between social security and the economy. Finds that "the historical evidence fails to support the hypothesis that social security has reduced private saving."

Munnell, Alicia H.
The impact of public and private pension schemes on saving and capital formation. International social security review, v. 39, no. 3, 1986: 243-257.

"Summarises evidence, primarily for the United States, on the relative effects of social security and private pension plans on personal saving."

Nolan, Thomas L., Jr.
Retire easy: the bluebook of retirement planning. [Manitowoc, Wisc.] National Press [1982] 275 p.
"Timely, insightful advice on IRA, All-Saver Certificates, investing, moving, part time jobs, real estate, financial planning, and social security."

Venti, Steven F. Wise, David A.
IRAs and saving. Cambridge, Mass., National Bureau of Economic Research, 1986. 67 p. (Working paper no. 1879)
"Increasing current Individual Retirement Account (IRA) limits would lead to substantial increases in tax-deferred saving according to evidence in the paper, based on the 1983 Survey of Consumer Finances. For example, the recent Treasury Plan would increase IRA contributions by about 30 percent. The primary focus of the paper, however, is the effect of limit increases on other saving. How much of the IRA increase would be offset by reduction in non-tax-deferred saving? The weight of the evidence suggests that very little of the increase would be offset by reduction in other financial assets, possibly 10 to 20 percent."

Vicker, Ray.
The Dow Jones-Irwin guide to retirement planning. Homewood, Ill., Dow Jones-Irwin, c1987. 332 p.

Weinstein, Grace, W.
Living the retirement years. New York, Public Affairs Committee, 1986. 24 p. (Public affairs pamphlets; no. 643)

Williamson, Samuel H. Jones, Warren L.
Computing the impact of social security using the life cycle consumption function. American economic review, v. 73, Dec. 1983: 1036-1052.
"The debate concerning the impact of Social Security on saving remains lively due to the continuing stream of contradictory empirical results. This paper offers an explanation of these contradictory results and demonstrates that the conclusions drawn from them are of highly questionable validity."

CONTINUUM OF CARE: HEALTH, SOCIAL, AND CUSTODIAL SERVICES

Abdellah, Faye G.
Long-term care policy issues: alternatives to institutional care. In Planning for the elderly. Philadelphia, American Academy of Political and Social Science, 1978. (Annals, v. 438, July 1978) p. 28-39.
"The Department of Health, Education, and Welfare has undertaken a major effort to include home health and social services as part of a broad cost containment effort to prevent inappropriate institutionalization. Home health and community services need to be linked with the total health care delivery system."

Abuse of the elderly: a guide to resources and services. Edited by Joseph J. Costa. Lexington, Mass., Lexington Books, c1984. 289 p.
"Organizes the sources and resources that are available to senior citizens, advocacy groups, and prevention organizations and informs those in need that someone does care."

Aging and public health. Edited by Harry T. Phillips and Susan A. Gaylord. New York, Springer, c1985. 325 p.

The Aging U.S. population and its impact on health care use and expense: a supplement to the Digest of National Health Care Use and Expense Indicators. [Chicago] American Hospital Association, Office of Health Coalitions and Private Sector Initiatives, 1987. 28 p.
"Compiled for the Dunlop Group of Six: American Federation of Labor--Congress of Industrial Organizations; American Hospital Association; American Medical Association; Blue Cross and Blue Shield Association; Business Roundtable; Health Insurance Association of America."
Partial contents.--Demographic trends.--Ratios of old/young to workers.--Public sector health care coverage for the elderly.--Medicare enrollment.--Medicaid payments for the elderly.--Private sector health care coverage for the elderly.--Long term care insurance.--Delivery system changes addressing the needs of the elderly.

Alter, Catherine Foster.
The changing structure of elderly service delivery systems. Gerontologist, v. 28, Feb. 1988 91-98.
Assumes the impact of integrating block grant Medicaid programs with the Administration on Aging's original Area Agencies' funding system. Finds more centralized and differentiated bureaucratic structures among elderly service systems in the States.

The American public views long term care; a survey conducted for the American Association of Retired Persons and The Villers Foundation, by R. L. Associates. Princeton, N.J., R. L. Associates, 1987. 27 p.

Anetzberger, Georgia Jean.
The etiology of elder abuse by adult offspring. Springfield, Ill., C. C. Thomas, c1987. 130 p.
Identifies "abuse socialization, pathology and personality (particularly authoritarianism), social isolation, and acute stress for the adult offspring; vulnerability of the elderly patient; and intimacy between the victim and the abuser. Implications for public policy and program planning are discussed."

Balzano, Michael P.
Federalizing meals-on-wheels: private sector loss or gain? Washington, American Enterprise Institute for Public Policy Research [1979] 41 p. (American Enterprise Institute for Public Policy Research. Special analysis, no. 79-1)
Study analyzes "the creation of a federal meals-on-wheels program, to determine its potential impact on one mediating structure, the private voluntary organizations currently operating meals-on-wheels programs . . . . It will attempt to discover, first, if the new federal program will make maximum use of the mediating structures by utilizing the existing voluntary

organizations. Second, it will determine if the federal program has been constructed so that at a minimum it will not harm existing private meals-on-wheels programs."

Bengtson, Vern I.
Transportation: the diverse aged. [Washington, U.S. National Science Foundation, for sale by the Supt. of Docs., G.P.O.] 1976. 84 p.
"Policy report one."
"NSF/RA 77-0023"
"USC research program on social and cultural contexts of aging."
Report "investigates the transportation patterns and problems of older persons. Three methods are employed: (a) an examination of available literature in the field of transportation and the aged; (b) an analysis of primary research data, reflecting two surveys conducted in 1973-75; (c) an analysis of past and current transportation policy."

Branch, Laurence G. Jette, Alan M.
The Framingham disability study: social disability among the aging. American journal of public health, v. 71, Nov. 1981: 1202-1210.
"Reports results on the prevalence of social disability in five areas: housekeeping, transportation, social interaction, food preparation, and grocery shopping. Only 6 per cent of the sample have existing unmet needs in one or more of these five areas. The magnitude of social disability increases with advancing age. Women, in general, report a higher degree of unmet social needs than men."

Brecher, Charles. Knickman, James.
A reconsideration of long-term-care policy. Journal of health politics, policy and law, v. 10, summer 1985: 245-273.
Article "describes the two major problems of public long-term care programs: inappropriate services and inequitable funding; . . . shows why current problems will worsen if present policies are continued for the next ten to fifteen years; . . . and presents some alternatives to continuing our present policies, and describes the impact of each option on the living conditions of the frail elderly, on public budgets, and on the private burdens borne by the families of the frail elderly."

Brody, Elaine M.
The aging of the family. In Planning for the elderly. Philadelphia, American Academy of Political and Social Science, 1978. (Annals, v. 438, July 1978) p. 13-26.
"A central policy issue is the development of services for older people in the United States, specifically the extent to which families can be expected to continue to provide the bulk of needed services vis-a-vis community responsibility."

Brody, Stanley J.
Strategic planning: the catastrophic approach. Gerontologist, v. 27, Apr. 1987: 131-138.
"Three major societal responses to the perceptions of catastrophe for the aging family are traced. The first two, the needs for basic subsistence and for access to acute care medicine, were resolved . . . . The third and unresolved catastrophe, the need for continuity of care, is defined, popular perceptions of that need evaluated, and a policy solution suggested."

Dawson, Deborah. Hendershot, Gerry. Fulton, John.
Aging in the eighties: functional limitations of individuals age 65 years and over. NCHS [National Center for Health Statistics] advancedata, no. 133, June 10, 1987: 1-12.
Presents data from the 1984 National Health Interview Survey's Supplement on Aging.

Doty, Pamela. Liu, Korbin. Wiener, Joshua.
An overview of long-term care. Health care financing review, v. 6, spring 1985: 69-78.
"Long-term care (LTC) refers to health, social, and residential services provided to chronically disabled persons over an extended period of time. Especially during the last 20 years, State and Federal Governments have played an increasing role in the financing of long-term care. The aging of the population underlines the future importance of this topic. This article provides background data on need, supply, and expenditures; discusses government financing programs; and addresses quality of care concerns and options for LTC reform."

Eisele, Frederick R. Hoke, Richard R.
Health care policy and the elderly: toward a system of long-term care. Journal of health politics, policy and law, v. 3, winter 1979: 452-455.
"Argues that an appropriate health policy goal for the elderly for the 1980s would be to move toward a system of long-term care for the most vulnerable and health-costly elderly--the functionally disabled."

Elder abuse: a national disgrace: a report. By the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee of the Subcommittee on Aging, House of Representatives, Ninety-ninth Congress, first session. Washington, G.P.O., 1985. 64 p.
At head title: Committee print. "Comm. pub. no. 99-502."

Elder abuse and neglect: a guide for practitioners and policy makers. Designed and edited by Edwin Villmoare and James Bergman. Salem, Or., Oregon Office of Elderly Affairs, c1981. 181 p.
"Reviews the current research; presents intervention strategies and protocols; discusses model delivery systems and legislation; and provides information and materials for practitioner training and public education."

Elder abuse: conflict in the family. Edited by Karl A. Pillemer and Rosalie S. Wolf. Dover, Mass., Auburn House Pub. Co., c1986. 356 p.
Emphasizes prevention of abuse.

Elder abuse: public policy options other than direct service delivery. Washington, National Senior Citizens Law Center, 1983. 148 p.
"Describes elder abuse, current mechanisms of intervention and alternative preventive strategies."

Elderly abuse and quality assurance. Caring, v. 5, Jan. 1986: ca. 2-71 passim (40 p.)
Issue dedicated to the topic of abuse of the elderly, begins with testimony and reports from a series of congressional hearings. Then presents "four articles on the various aspects of elder abuse--its breadth and history, its victims and their attackers, and methods of identifying and preventing abuse and neglect in the home."

Emling, Diane Carpenter.
Adult chore services: a profile of in-home assistance. Lansing, Mich. Dept. of Social Services, 1976. 144 p. (Michigan. Dept. of Social Services. Studies in welfare policy no. 10)

The Evaluation of the national long-term care channeling demonstration; final report. Princeton, N.J., Mathematica Policy Research, Inc. (P.O. Box 2393), 1986. 190 p.
Prepared for the Dept. of Health and Human Services under contract. Reports on the use of informal caregiving, nursing homes, hospitals, and other services in the Federal demonstration program.

Faulkner, Lawrence R.
Mandating the reporting of suspected cases of elder abuse: an inappropriate, ineffective and ageist response to the abuse of older adults. Family law quarterly, v. 16, spring 1982: 69-91.

Feldbaum, Eleanor G. Feldbaum, Merle B.
Caring for the elderly: who dislikes it least? Journal of health politics, policy and law, v. 6, spring 1981: 62-72.
"Examines work plans of student nurses and work practices of registered nurses to ascertain who actually cares for the aged. Investigation of geriatric nurses reveals that few plan to or do work with the elderly."

Fulmer, Terry T. O'Malley, Terrence A.
Inadequate care of the elderly: a health care perspective on abuse and neglect. New York, Spring Pub. Co., 1987. 180 p.

Galin, Joseph J.
Transportation for the elderly, handicapped and disadvantaged: a bibliography of articles. Monticello, Ill., Vance Bibliographies, 1985. 9 p. (Public administration series: bibliography P-1659)

Transportation for the elderly, handicapped and disadvantaged: an annotated bibliography of technical reports. Monticello, Ill., Vance Bibliographies, 1985. 19 p. (Public administration series: bibliography P-1658)

Gerontological social work with families: a guide to practice issues and service delivery. Edited by Rose Dobrof. New York, Haworth Press, c1987. 184 p.
Published also as v. 10, nos. 1/2, January 1987, of the Journal of gerontological social work.

Goldberg, Richard T.
Alzheimer's disease: from benign neglect to community living. Rehabilitation literature, v. 46, May-June 1985: 122-132.
Looks at the causes and diagnosis of Alzheimer's disease as well as treatment and rehabilitation (i.e., community treatment and institutional care) programs, public policy, and ethical and religious issues concerning the disease.

Grady, Sally C. Maynard, Charles L.
Building ties: a mental health and aging project. Gerontologist, v. 27, no. 4, 1987: 428-429.
"The Building Ties Project provides comprehensive assistance to local interagency planning committees addressing the mental health service needs of elderly people, including training, program development materials, and consultation. Staff work with local agency staff for 1 year to improve interagency relationships, create new service programs, and develop mental health and aging policy recommendation. Over the past 2 years, project activities in 23 counties increased services, improved interagency cooperation, and brought wider recognition of older adults' service needs."

Health care financing: evaluation of community-oriented long-term care demonstration projects: extramural report [from evaluation contractor Berkeley Planning Associates, Calif.] Baltimore, Md., U.S. Health Care Financing Administration, Office of Research and Demonstration, for sale by the Supt. of Docs, G.P.O., 1987. 392 p. in various paging (HCFA pub. no. 03242)

Health statistics on older persons, United States, 1986. Hyattsville, Md. U.S. National Center for Health Statistics, For sale by the Supt. of Docs., G.P.O., 1987. 157 p. (DHHS publication; no. (PHS) 87-1409; Vital & health statistics. Series 3, Analytical and epidemiological studies; no. 25)

Hollonbeck, Darrell. Ohls, James C.
Participation among the elderly in the food stamp program. Gerontologist, v. 24, Dec. 1984: 616-621.
"It is estimated that approximately half of the elderly persons who are eligible for food stamps fail to take advantage of the benefits to which they are entitled. The most important reason for their non-participation appears to be their uncertainty or lack of knowledge about program eligibility, suggesting that professionals who work with the elderly should encourage them to take the steps necessary to determine their possible eligibility. Perceived stigma and transportation barriers are also factors leading to non-participation for some elderly persons."

Isaacs, Mareasa R. Goldman, Sybil K.
State initiatives in long-term care: report of a survey of 32 states. [Washington] U.S. Dept. of Health and Human Services, Bureau of Health Maintenance Organizations and Resources Development, Office of Health Planning; reproduced by NTIS, 1984. 62, 18 p.
"HRP-0905897, Aug. 1984"
Partial contents.--Key state policy issues in long-term care.--Federal and private sector demonstration projects: new resources for the provision and financing of long-term care services.--State coordination of long-term care.--Changes in the delivery and financing of long-term care services.

Janicki, Matthew P. MacEachron, Ann E.
Residential, health, and social service needs of elderly developmentally disabled persons. Gerontologist, v. 24, Apr. 1984: 128-137.
"Offers survey-derived demographic, disability characteristic, living setting, and health and social service receipt and need information on a population of 7,823 such persons age 53 and older. Additional information is presented by age groups and residential settings. Both similarities and

dissimilarities were noted between elders in general and age peers who were also developmentally disabled. Comment's are offered relating the information to public policy considerations."

Justice, Diane.
State iniatives in reforming long-term care. Business and health, v. 4, Dec. 1986: 14-16, 18-19.

Kemper, Peter. Applebaum, Robert.
Community care demonstrations: what have we learned? Health care financing review, v. 8, summer 1987: 87-100. (Also reprinted by the U.S. National Center for Health Services Research and Health Care Technology Assessment.)

"Conclude[s] that expanding public financing of community services beyond what already exists is likely to increase costs . . . . The focus of attention gradually shifted to whether home care, including nonmedical services such as personal care and homemaker services, can substitute for nursing home care."

A systematic comparison of community care demonstrations, by Peter Kemper, Robert Appelbaum, and Margaret Harrigan [Washington] U.S. National Center for Health, Services, Research and Health Care Technology Assessment, 1987. 131 p. (Institute for Research on Poverty special report)

Prepared as part of a DHHS contract for the channeling evaluation, under sponsorship of the Institute for Research on Poverty at the University of Wisconsin, Madison. Evaluates demonstration programs and other experiments in community care of the frail elderly.

Kermis, Marguerite D.
The epidemiology of mental disorder in the elderly: a response to the Senate/AARP report. Gerontologist, v. 26, Oct. 1986: 482-487.

"A recent report prepared by the Senate Select Committee on Aging and the AARP Aging America: Trends and Projections suggests that older people have a lower prevalence of mental health problems than any other age group . . . . The report also states that this leads to the underutilization of mental health services by older people. Alternative interpretations are presented, which suggest high rates of mental health problems in old age are accompanied by an unmet need for services. Problems in governmental policies and the shifting site of care are presented as contributors to the low use of services."

Knight, Bob. Walker, Deborah Lower.
Toward a definition of alternatives to institutionalization for the frail elderly. Gerontologist, v. 36, Aug. 1985: 358-363.

"The literature on alternatives to institutionalization for the frail elderly has suffered from a lack of clear definitions of key terms. An analysis of selected literature on the question leads to proposed definitions of 'frail elderly' and 'range of institutional care.' Based on these definitions, it is argued that an active problem-solving, treatment-oriented approach can reduce unnecessary institutionalization and that the movement to deinstitutionalize the elderly can learn from the history of the deinstitutionalization of other groups."

Krout, John A.
Notes on policy and practice. Social service review, v. 58, June 1984: 281-290.

"Examines levels of service awareness and use, correlates of use, and reasons for nonuse for a sample of 250 residents aged sixty and over of a small city. A regression analysis reveals that service use is greater for those elderly who are aware of more services, are not married, have less education, use their cars less, report a greater number of sick days, and have less contact with their children. Lack of need is identified as the major reason for nonuse."

Kruzich, Jean M. Berg, William.
Predictors of self-sufficiency for the mentally ill in long-term care. Community mental health journal, v. 21, fall 1985: 198-207.

"Identifies the facility, community and client characteristics that predict the level of self-sufficiency of clients in long term care. Three settings are included: combined skilled nursing and intermediate care facilities, free-standing intermediate care facilities and congregate care facilities."

Landsberger, Betty.
Long-term care for the elderly: a comparative view of layers of care. New York, St. Martin's Press, 1985. 239 p.

Legal and ethical aspects of health care for the elderly. Edited by Marshall B. Kapp, Harvey E. Pies, Jr., and A. Edward Doudera. Ann Arbor, Mich., Published in cooperation with the American Society of Law and Medicine [by] Health Administration Press, 1985, c1986. 322 p.
Based on a conference held in June 1983 in Washington, D.C.; sponsored by the American Society of Law & Medicine.

Leisure and aging. Parks and recreation, v. 21, Aug. 1986: 35-51, 63.
Contents.--An incentive for living, by Ladd Colston.--Nursing home recreation: an unchanging diet of bingo, birthdays and Bible? by Barbara Wilhite and Joseph D. Teaff.--Aging and leisure resource directory.--Aging and leisure bibliography.

Lockett, Betty A.
Setting the Federal agenda for health research: the case of the National Institute on Aging. Journal of health politics, policy and law, v. 9, spring 1984: 63-80.
"Describes the creation of the National Institute on Aging at the National Institutes of Health, as a case study in 'agenda-building.' . . . This case study illustrates how biomedical research policy evolves when the federal government fails to take the lead in developing an overall strategy, not only for research on aging, but also for all areas of biomedical research."

Long-term care. Caring, v. 6, Oct. 1987: whole issue (76 p.)
Partial contents.--Long-term care: a crisis in the making, by Frank E. Moss.--Long-term care: the time is now, by Jennifer Belk.--Long-term care: filling the gaps, by Val. J. Halamandaris.--Nursing supply and long-term care: the nursing shortage comes home, by Patricia A. Jones and Debra Hardy.--Long-term care and dementia.--Long-term care: a women's issue.

Losing a million minds: confronting the tragedy of Alzheimer's disease and other dementias. Washington, U.S. Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1987. 539 p.
"OTA-BA-323, Apr. 1987"
Presents goals of public policy relating to dementia. Long term goals include finding ways to eliminate the diseases causing dementia. "Near-term goals include training caregivers (family, volunteer, and professional), improving care practices in acute and long-term care, and devising means to pay for the catastrophic expenses brought on by dementing illness."

Matthews, Sarah H.
Participation of the elderly in a transportation system. Gerontologist, v. 22, Feb. 1982: 26-31.
"Data collected through field research for 1 year in a transportation system for the elderly document the erosion of an elderly constituent's effective participation. The definitions of the ideal passenger to which each component of the organization and each funding source subscribed are compared to show how and why the erosion came about. It is suggested that transportation services may depend for their survival on promoting the effective participation of passengers."

May, William F.
New ways to honor father & mother. Christianity today, v. 28, Oct. 5, 1984: 39-44.
Urges that both the government and voluntary communities have vital roles in providing strategies for care of the elderly with respect to the ethical needs of the aged themselves. Finds a societal need to recognize that adults are beneficiaries of the older generation to prevent "an age of resentment and hostility toward the elderly."

McAuley, William J. Blieszner, Rosemary.
Selection of long-term care arrangements by older community residents. Gerontologist, v. 25, Apr. 1985: 188-193.
"Examined the distribution and patterning of responses to five long-term care arrangements as well as factors associated with various choices. Older adults most frequently preferred care from a relative or paid helper

in their own homes and selected moving into a relative's home least often. Marital status, income, race, and availability of extended informal support were significantly associated with at least three arrangement choices."

Moran, R. Allen.
Services for the elderly: some empirical findings on agency managers' preferences. Evaluation review, v. 6, Dec. 1982: 843-849.

"Presents sample data from a recently completed study of the preferences of managers of agencies providing services to elderly persons. These data suggest specific types of managerial preferences and also show that these preferences may be at odds with both agency funding sources and public policy objectives."

Myrtle, Robert C. Lammers, William W. Klingman, David.
Long term care regulation in the States: a systemic perspective. Policy studies review, v. 5, Nov. 1985: 337-348.

"The factors which have contributed to regulatory policies for long term care show some potential for strong state action but also several definite limitations. There are indications of factors which encourage states to engage in strong regulatory responses, but also important suggestions that the absence of an active pattern of using state government and the organizational capacity to handle complex issues, coupled with potentials for agency capture by provider interests, can seriously reduce the likelihood of significant state action."

National Governors' Association. Center for Policy Research. Health Policy Studies.
Building affordable long term altenatives: integrating State policy. Washington, The Association, 1987. 260 p. in various paging. 260 p.

Partial contents.--The Federal policy and budget context.--State role.--Private financing and insurance alternatives.

Naylor, Mary D.
The health status and health care needs of older Americans; an information paper prepared for use by the Special Committee on Aging, United States Senate. Washington, G.P.O., 1986. 37 p. (Print, Senate, 99th Congress, 2nd session, committee print S. Prt. 99-200)

"Serial no. 99-L"

Netting, F. Ellen. Hinds, Howard N.
Volunteer advocates in long-term care: local implementation of a Federal mandate. Gerontologist, v. 24, Feb. 1984: 13-15.

"Describes the volunteer advocacy program developed by the East Tennessee Advocacy Assistance Program. Its purpose is to assist the ombudsman/director in resolving problems and complaints made by residents in long-term care facilities. Effective volunteer participation requires intensive training, well-defined policies and procedures, coordination with aging network and long-term care professionals, and adequate supervision of volunteers."

Parmelee, Patricia A.
Protective services for the elderly: do we deal competently with imcompetence? Law & policy quarterly, v. 2, Oct. 1980: 397-419.

Examines "the philosophy, statutes, and procedures of legal protective services for the elderly, attempting at each level to demonstrate how intervention imperils old people's legal and psychological rights. ... Whether it be process or product, the effect of legal intervention is substantially to reduce elders' control over their own lives."

Pepper, Claude.
Abuses in guardianship of the elderly and infirm: a national disgrace; briefing by the Chairman of the Subcommittee on Health and Long-term Care of the Select Committee on Aging, House of Representatives, 100th Congress, 1st session. Washington, G.P.O., 1988. 136 p.

At head of title: Committee print.

"Comm. pub. no. 100-641"

Reprints a "Statement of recommended judicial practices adopted by the National Conference of the Judiciary on Guardianship Proceedings for the Elderly," compiled by Erica Wood, sponsored by the Commission on Legal Problems of the Elderly, American Bar Association and the National Judicial College, p. 81-136.

Abuses in guardianship of the elderly and infirm: a national disgrace; a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, 100th Congress, 1st session. Washington, G.P.O., 1987. 92 p.

At head of title: Committee print.

"Comm. pub. no. 100-639"

Includes 2 appendices, an Associated Press series on guardianship p. 13-57 and "Wards of the Court," a series of the St. Petersburg Times, Dec. 14-21, 1986, p. 58-92.

Personnel for health needs of the elderly through Year 2000; report to Congress by the U.S. Dept. of Health and Human Services, National Institute on Aging. Bethesda, Md., U.S. National Institute on Aging, 1987. 199 p. (NIH publication no. 87-2950)

Partial contents.--Home and community-based services.--Health promotion and disease prevention.--Long-term care gerontology centers.

Pillemer, Kar. Finkelhor, David.

The prevalence of elder abuse: a random sample survey. Gerontologist, v. 28, Feb. 1988: 51-57.

"In this first large-scale random sample survey of elder abuse and neglect, interviews were conducted with 2020 community-dwelling elderly persons in the Boston metropolitan areas regarding their experience of physicial violence, verbal aggression, and neglect. The prevalence rate of overall maltreatment was 32 elderly persons per 1000. Spouses were found to be the most likely abusers and roughly equal numbers of men and women were victims, although women suffered more serious abuse." Public policy issues include the need for education of service providers and the elderly victims themselves as well as the need for programs on the problem of spouse abuse.

Poister, Theodore H.

Federal transportation policy for the elderly and handicapped: responsive to real needs? Public administration review, v. 42, Jan.-Feb. 1982: 6-14.

"Traces the evolution of federal policy concerning transportation for the E&H and attempts to determine what that policy is supposed to achieve and what its impact actually will be. The primary argument to be advanced is that as the policy currently stands it will not tangibly benefit the majority of the target population."

Polchow, Michelle.

Ideas for long-term care. State legislatures, v. 12, Nov.-Dec. 1986: 26-29.

"The false assumption that they can afford the care they need is forcing many elderly Americans into the poorhouse. But there are plenty of new ideas for serving the needs of the country's fastest-growing population"--including long-term care insurance, home equity conversion programs, medical IRA's, and life-care communities.

Powell, Sharon. Berg, Robert C.

When the elderly are abused: characteristics and intervention. Educational gerontology, v. 13, Jan. 1987: 71-83.

Identifies types of abuse: "physical, financial, emotional, passive neglect, and active neglect. Financial abuse was noted most frequently, and multiple types of abuse were noted in most cases with the combination of physical, financial, and emotional abuse being observed most frequently. Fifteen different categories of case management strategies were examined, averaging four different assistance strategies per case. Legal services appeared to be the most often refused form of assistance. The study found no evidence that those who abuse the elderly are being prosecuted."

A Prospective study of incident comprehensive medical home care use among the elderly, by Laurence G. Branch and others. American journal of public health, v. 78, Mar. 1988: 255-259.

Found indicators of frailty in physical and cognitive functions which are predictive of both use of medical home care and of subsequent entrance into nursing homes.

Problems facing elderly Americans living alone: a national survey conducted for the Commonwealth Fund Commission on Elderly People Living Alone. New York, Louis Harris and Associates [1987] 90, 27 p. (Study no. 854010)

Reports results of a June-July 1986 telephone survey of 2002 people aged 65 and over, and 504 more people aged 75 and over, who live alone in the community, not in institutions. A representative sample is found to be "disproportionately female, widowed, without children, older, and poorer, compared to elderly people who live with someone else."

Public policy, the private nonprofit sector and the delivery of community-based long term care services for the elderly; final report. San Francisco, Aging Health Policy Center, University of California, 1983. 2 v.
Volume 2 is an executive summary of the final report.
Presents an analysis of a 1983 telephone survey of mainly private nonprofit community-based service providers and of private and nonprofit funders of these agencies, conducted in eight states and 32 communities. Examines the "fate of the community-based systems" for long term care services to the elderly (not institutional care) with respect to their facing cutbacks in Federal funds; having to compete with State and local governments and each other for Federal and private funding; and the growing competition with proprietary providers in some service areas.

Rabin, David. Stockton, Patricia.
Long-term care for the elderly: a factbook. New York, Oxford University Press, 1987. 248 p.
"Funded by a grant from the Robert Wood Johnson Foundation."

Ranii, Dave.
Meals on wheels: how to turn victory into defeat--and back into victory. National journal, v. 12, Mar. 29, 1980: 522-524.
"In their quest for federal aid to help them deliver meals to the homebound elderly, volunteer Meals on Wheels groups nearly had to surrender control of their service to the federal bureaucracy. Now, nearly 18 months after Congress approved the aid, it doesn't look as if Meals on Wheels will receive much federal aid after all."

Read, William A. O'Brien, James L.
New trends in hospital-based services for the elderly. Trustee, v. 39, Sept. 1986: 20-22.
"An American Hospital Association survey reveals the types of services hospitals currently provide, including specialized geriatric programs, and what services they are likely to provide in the future."

Regulating health care: the struggle for control. New York, Academy of Political Science, 1980. 244 p. (Academy of Political Science, New York. Proceedings, v. 33, no. 4)
Partial contents.--The political environment of regulation.--The cost of hospital regulation.--The regulation of health insurance.--Federal-state conflicts in cost control.--The regulation of nursing homes: a case study.

Riessman, Frank. Moody, Harry R. Worthy, Edmund H., Jr.
Self-help and the elderly. Social policy, v. 14, spring 1984: 19-26.
Describes "a number of self-help, mutual aid activities involving older people."

Salamon, Michael J.
A basic guide to working with elders. New York, Springer, c1986. 212 p.

Scanlon, William J. Feder, Judith.
The long-term care marketplace: an overview. Healthcare financial management, v. 14, Jan. 1984: 18-19, 24-26, 28, 30, 34, 36.
"Provides an overview of the long-term care marketplace, identifying the long-term care population, examining how population and policy changes have affected the use and nature of long-term care services up to now, and exploring how future population and socio-economic changes are likely to influence the long-term care market."

Shapiro, Evelyn. Roos, Noralou P.
Retired and employed elderly persons: their utilization of health care services. Gerontologist, v. 22, Apr. 1982: 187-193.
"Compares the health care used by employed and retired elderly persons. . . . The findings indicate that ambulatory physician visitation of both groups is similar, and the greater prevalence of serious conditions among the retired is associated with their higher hospitalization rates rather than with their retirement status."

Sherwood, Sylvia. Morris, John N. Ruchlin, Hirsch S.
Alternative paths to long-term care: nursing home, geriatric day hospital, senior center, and domiciliary care options. American journal of public health, v. 76, Jan. 1986: 38-44.
"Examines certain quality of life outcomes, as well as comparative costs of care, for selected types of persons entering three very distinct types of alternative service programs that address the long-term care needs of vulnerable elderly persons. . . . Except for the issue of institutionalization, quality of life impact analysis showed only a few more post-test differences than would be expected by chance (although the few post-test differences that were observed in each case favored less restrictive settings). This more general similarity of outcome is indeed provocative, suggesting that in many ways the applicants adapted similarly to these quite distinct programs. Cost analyses found that nursing home and geriatric day hospital care, the two most restrictive settings, were also the two most expensive interventions."

Shifting commitments to long-term care: the role of coordination. Gerontologist, v. 24, Dec. 1984: 598-603.
"A mail survey of all state and local health planning agencies and telephone interviews with a sample of Older Americans Act agencies revealed that coordination between aging and health planning agencies is directly associated with the level of attention given to long-term care priorities by the latter agencies. The findings suggest that under certain conditions, coordination strategies may be important for policy change."

Social work with the aging. Edited by Carol H. Meyer. Silver Spring, Md., National Association of Social Workers, c1986. 257 p. (Readings in social work series)

Somers, Anne R.
The geriatric imperative. Hospitals, v. 57, May 1, 1983: 77-78, 81.
Argues that hospitals need to change their long-term care policy to fit new geriatric care needs.

Rethinking health policy for the elderly: a six-point program. Inquiry (Chicago), v. 17, spring 1980: 3-17.
Offers six essential elements for consideration for a national health policy for the elderly: income maintenance, medicare reform, new program for long-term care for the emotionally disabled, reform of a residual medicaid, eventual incorporation of medicare and medicaid, and volunteer services.

Stone, Robyn.
Aging in the eighties, age 65 years and over--use of community services. NCHS [National Center for Health Statistics] advancedata, no. 124, Sept. 30, 1986: 1-8.
Reports preliminary data from the Supplement on Aging to the National Health Interview Survey: United States, January-June 1985 [sic, 1984].

Streib, Gordon F.
The frail elderly: research dilemmas and research opportunities. Gerontologist, v. 23, Feb. 1983: 40-44.
Concludes that "many areas in which more research is needed can be identified when one focuses on the frail elderly. It is important to study this group not only because of the inherent research and intellectual challenge it presents but also because of the policy implications that are related to this target group."

Torres-Gil, Fernando. Pynoos, Jon.
Long-term care policy and interest group struggles. Gerontologist, v. 26, Oct. 1986: 488-495.
"Examined were how interest group struggles affect the formulation and implementation of a statewide long-term care system using California's experience to illustrate the competition that can develop between senior citizens and disabled groups."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Problems and issues in long-term care. Hearings, 99th Congress. Washington, G.P.O., 1986. 392 p.

"Serial no. 99-71"
Hearings on "long-term care services for the elderly, Oct. 18, 1985; Alzheimer's disease and related disorders, Jan. 27, 1986."

U.S. Congress. House. Select Committee on Aging.
America's elderly at risk; a report prepared by the Chairman of the Select Committee on Aging, House of Representatives, 99th Congress, 1st session. Washington, G.P.O., 1985. 34 p.
At head of title: Committee print.

Continuing care: international prototypes for America's aged. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1985. 279 p.
Hearing held in New York City on July 15, 1985.
"Comm. pub. no. 99-523"

Elder abuse (an examination of a hidden problem); a report (with additional views) 97th Congress, 1st session. Apr. 3, 1981. Washington, G.P.O., 1981. 169 p.
"Comm. pub. no. 97-277"
At head of title: Committee print.
"Concludes that elder abuse is an extremely serious, widespread, and . . . largely hidden problem in the United States [and] that there is immediate need for action at both the State and Federal level to prevent the problem from occurring in the future."

Elder abuse: the hidden problem; a briefing . . . . 96th Congress, 1st session. Washington, G.P.O., 1980. 115 p.
At head of title: Committee print.
"Comm. pub. no. 96-220."

Long-term care for the elderly: Louisiana's experience. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1985. 172 p.
Hearing held on Jan. 25 in 1985, New Orleans.
"Comm. pub. no. 99-500"

Long-term care for the Indian elderly. Oversight hearing before the Select Committee on Aging and the Committee on Interior and Insular Affairs, House of Representatives, 98th Congress, 2nd session. Washington, G.P.O., 1985. 280 p.
Hearing held in Tucson, Ariz., May 25, 1984.
"Select Committee on Aging: Serial no. 98-475; Committee on Interior and Insular Affairs: Serial no. 98-45"

Long-term care in America: the people's call for Federal action. Hearing, 99th Congress, 1st session. June 4, 1985. Washington, G.P.O., 1985. 22 p.
"Comm. pub. no. 99-515"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Elder abuse. Hearing, 99th Congress, 1st session. May 10, 1985. Washington, G.P.O., 1985. 158 p.
"Comm. pub. no. 99-516"
Presents testimony from State officials on the extent of elder abuse in their States as well as whether Federal legislation to deal with this problem would be appropriate.

Long-term care: need for a national policy. Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 115 p.
"Comm. pub. no. 98-444"
Hearing held Dec. 15, 1983, San Francisco, Calif.

Problems of the elderly: Central States Coalition on Aging. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1987. 97 p.
Hearing held Aug. 9, 1986 in Kansas City, Mo.
"Comm. pub. no. 99-609"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Housing and Consumer Interests.
Social service needs of elder minorities. Hearing, 96th Congress, 2d session. Washington, G.P.O., 1981. 39 p.
Hearing held Sept. 13, 1980, Pacoima, Calif.
"Comm. Pub. no. 96-271"

The tragedy of elder abuse: the problem and the response. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 57 p.
Hearing held July 1, 1986 in Nashville, Tenn.
"Comm. pub. no. 99-580"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Human Services.
Elderly transportation--1986 and beyond. Hearing, 99th Congress, 2nd session. Mar. 12, 1986. Washington, G.P.O., 1986. 131 p.
"Comm. pub. no. 99-563"

The long-term care ombudsman program: a decade of service to the institutionalized elderly. Hearing, 99th Congress, 1st session. Sept. 10, 1985. Washington, G.P.O., 1986. 149 p.
"Comm. pub. no. 99-537"

U.S. Congress. House. Select Committee on Hunger. Domestic Task Force.
Hunger and the elderly. Joint hearing before the Domestic Task Force of the Select Committee on Hunger and the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Apr. 22, 1986. Washington, G.P.O., 1986. 109 p.
"Comm. pub. no. 99-572"

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health.
Long-term health care. Hearing, 98th Congress, 1st session. Nov. 3 and 14, 1983. Washington, G.P.O., 1984. 596 p. (Hearing, Senate, 98th Congress, 1st session, S. Hrg. 98-732)

Long-term health care. Hearing, 100th Congress, 1st session. Feb. 24, 1987. Washington, G.P.O., 1987. 405 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-35)

U.S. Congress. Senate. Select Committee on Aging.
Aging veterans in an aging society: public policy at a crossroads; a report presented by the Chairman of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Washington, G.P.O., 1986. 58 p.
At head of title: Committee print.
"Comm. pub. no. 99-555"

U.S. Congress. Senate. Special Committee on Aging.
Long-term needs of the elderly: a Federal-State-private partnership. Hearing, 98th Congress, 2nd session. Washington, G.P.O., 1984. 138 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-1087)
Hearing held in Seattle, Wash., July 10, 1984.

Meeting the present and future needs for long-term care. Hearing, 98th Congress, 2nd session. Washington, G.P.O., 1984. 32 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-795)
Hearing held in Jersey City, N.J., Feb. 27, 1984.

U.S. Dept. of Health and Human Services. Task Force on Long-Term Health Care Policies.
Report to Congress and the Secretary. Baltimore, MD, U.S. Dept. of Health and Human Services, Health Care Financing Administration; Washington, available from Supt. of Docs., G.P.O., 1987. 322 p. (HCFA pub.; no. 87-02170)

U.S. General Accounting Office.
Federal and state actions needed to overcome problems in administering the Title XX program; report to the Congress by the Comptroller General of the United States. [Washington] 1980. 40 p.
"HRD-81-8, Oct. 29, 1980"

"GAO recommends that the Secretary of Health and Human Services improve State contracting by encouraging the use of contracts based on unit prices or specific levels of service and encourage States that authorize elderly persons to hire their own homemaker and chore services providers to monitor the quality of services and assure that the required hours are delivered.

Improved knowledge base would be helpful in reaching policy decisions on providing long-term, in-home services for the elderly; report to the Honorable Pete V. Domenici, United States Senate. [Washington] 1981. 43 p.

"HRD-82-4, Oct. 26, 1981"

"Four Federal programs provide some type of long-term, in-home services. Each program has restrictions limiting the availability of services. Little is known about the ramifications of removing these restrictions. In addition, studies have not provided conclusive evidence on how well long-term, in-home care would prevent or delay institutionalization of the elderly."

Participants are satisfied with mandatory meal programs in HUD projects; report by the U.S. General Accounting Office. Mar. 5, 1985. Washington, G.A.O., 1985. 36 p.

"GAO/RCED-85-67"

"The Department of Housing and Urban Development permits owners of section 202 housing projects for the elderly to adopt a mandatory meal policy that requires residents to purchase no more than one meal per day as a condition of occupancy. HUD intends this policy to benefit elderly residents by providing them with balanced meals and an increased opportunity to socialize with others."

U.S. Health Care Financing Administration.
Long term care: background and future directions. [Washington] 1981. 72 p. (U.S. Dept. of Health and Human Services. HCFA 81-20047)

Partial contents.--The need for long term care services.--Long term care services and settings.--Problems of the current long term care system.--Key policy research questions surrounding the expansion of noninstitutional services.--Options and strategies for long term care reform.

U.S. Interagency Statistical Committee on Long-Term Care for the Elderly.
Data coverage of the functionally limited elderly: report. Statistical reporter, no. 80-10, July 1980: 281-316.

Develops an inventory of existing and planned data sources on long-term care for the elderly. "Assesses the adequacy of their coverage in relation to major LTC policy issues, and makes recommendations for obtaining needed data."

U.S. Transportation Systems Center. Technology Sharing Office.
Transportation for the elderly and handicapped: program and problems II. Cambridge, Mass., For sale by the Supt. of Docs., G.P.O., 1980. 193 p.

"This is the third publication on transportation for the elderly and handicapped issued within a four-year period by the Office of Technology Sharing at the U.S. DOT Transportation Systems Center in Cambridge, Massachusetts. Readers of previous publications will be interested in what appears to be a changing emphasis--from planning to implementation--which is reflected in the chapters in this present publication." The companion publications are Transportation and the elderly and handicapped: a literature capsule, and Transportation for the elderly and handicapped: programs and problems.

Vladeck, Bruce C. Firman, James P.
The aging of the population and health services. In Health care policy in America. Philadelphia, American Academy of Political and Social Science, 1983. (Annals, v. 468, July 1983) p. 132-148.

"The demographic revolution--engendered in large part by modern medicine--which has led to the extraordinary and continuing increase in the number and proportion of elderly persons in the population has profound implications for health services. The elderly are disproportionately heavy utilizers of health care, primarily because of the prevalence of chronic disease. In the United States most health care for the elderly is financed through public funds, and costs have been increasing at an alarming rate. There is wide consensus that, for all the excellence of performance of the medical care system in treating acute episodes, care of chronic disease is frequently satisfactory in both quality and cost. Given the demographic imperatives, reform of mechanisms for chronic care is thus essential."

Wachs, Martin, and others.
Determing the future mobility needs of the elderly: development of a methodology, volume II. Washington, U.S. Dept. of Transportation, Transportation Programs Bureau, available from NTIS, 1977. 183 p.
"The transportation needs of the elderly are examined and forecast to the year 2000 with particular emphasis on the relationships between travel and a variety of lifestyles among the elderly. Using lifestyle groups identified during the prior year's research, this study forecasts the population and travel patterns of senior citizens in each lifestyle group to the year 2000. Although the methodology developed is applicable to any metropolitan area, a specific case study of Los Angeles is presented."

Watson, Wilbur H. McGhee, Nelson, Jr. Reed, Wornie L.
Health policy and the Black aged. Urban League review, v. 10, winter 1986-87: 63-71.
"In the context of the growing numbers of older, frail and poor blacks under conditions of increasing health care costs, on the one hand, and federal cutbacks in public assistance programs on the other, and the problem of out-of-pocket costs and health care for older blacks are examined."

Weissert, William G.
Estimating the long-term care population: prevalence rates and selected characteristics. Health care financing review, v. 6, summer 1985: 83-91.
Intends to "define the long-term care population in terms relevant to public policy considerations; and present key characteristics of this defined population, particularly those characteristics relevant to making service need estimates, including institutional care."

Seven reasons why it is so difficult to make community-based long term care cost-effective. Health services research, v. 20, Oct. 1985: 423-431.
"Few who use home- and community-based long-term care would otherwise have been long-stayers in nursing homes. Long-stayers tend to be older, sicker, more dependent, and poorer in social resources than those who use community care."

Yordi, Cathleen L. Waldman, Jacqueline.
A consolidated model of long-term care: service utilization and cost impacts. Gerontologist, v. 25, Aug. 1985: 389-397.
"Service utilization and cost impacts of a consolidated model of long-term care for functionally impaired elderly were assessed using a quasi-experimental research design. Compared to the traditional long-term care system, a consolidated model of long-term care reduces the number of days of hospital and nursing home care, redistributes health care dollars from expensive institutional care toward a broader range of less costly services provided in a community-based setting, and reduces the overall cost of long-term care."

FINANCING LONG-TERM CARE AND HEALTH CARE FOR THE AGED

Anlyan, William G., Jr. Lipscomb, Joseph.
The national health care trust plan: a blueprint for market and long-term care reform. Health affairs, v. 4, fall 1985: 5-31.
Makes a proposal involving "long-term care, tax-exempt health insurance, and the private sector role. The authors' scheme, called the National Health Care Trust Plan, would restructure tax incentives that influence the purchase of private health insurance and personal savings decisions."

Avorn, Jerry.
Benefit and cost analysis in geriatric care: turning age discrimination into health policy. New England journal of medicine, v. 310, May 17, 1984: 1294-1310.
"Explores the limitations and inequities of cost-effectiveness and cost-benefit analyses, particularly as they apply to the elderly."

Feder, Judith. Scanlon, William J.
Federal financing and fiscal incentives: shuffling Federal programs to pay for long-term care. Washington, Urban Institute, 1983. 45 p. (Working paper 1466-15)

Ferrara, Peter J.
Averting the Medicare crisis: Health IRAs. Washington, Cato Institute, 1985. 13 p. (Policy analysis no. 62)
Argues that proposed legislation providing for Health IRAs can solve the "long-term Medicare financing problem . . . without benefit cuts for the elderly or payroll tax increases for workers."

The Financial capacity of the elderly to insure for long-term care. Gerontologist, v. 27, no. 4, 1987: 494-502.
"Considered was the financial capacity of the elderly for purchasing any of four emerging long-term care plans: Social/Health Maintenance Organizations, long-term care insurance, Life Care at Home, and Continuing Care Retirement Communities. Between 50% to 80% of all elderly could afford to purchase one of these plans depending on the amount of discretionary income they would be willing to spend. The market for these options will largely be determined by the willingness of the elderly to spend assets."

Financing care for patients with Alzheimer's disease and related disorders; a briefing by the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Washington, G.P.O., 1986. 35 p.
At head of title: Committee print.
"Comm. pub. no. 99-596"
"Outgrowth of a one-day workshop held in May, 1986 and sponsored by seven Representatives and ten Senators," which "focused on a paper that was written by Dr. Karen Davis and Ms. Patricia Neuman of Johns Hopkins University."

Financing long-term care. EBRI issue brief, no. 48, Nov. 1985: 1-11.
"Evaluates demographic changes and health care expenditures of the elderly and the risks associated with chronic health conditions. Existing financial mechanisms are explored, as are alternative approaches to long-term care financing. The financing of long-term care is the most fundamental issue discussed."

Gabel, Jon R. Toth, Cindy. Williams, Karen.
A snapshot of the private market in long-term care. Business and health, v. 4, May 1987: 34-36, 38-39.
Reports on a June 1986 survey by the Health Insurance Association of America in which eighteen of 335 member companies reported offering long-term care insurance.

Gregory, David L.
COBRA: Congress provides partial protection against employer termination of retiree health insurnace. San Diego law review, v. 24, 1987: 77-100.
"Article examines COBRA Consolidated Omnibus Budget Reconciliation Act, its mechanics, and its shortcomings. This Article also analyzes pre-COBRA judicial decisions relating to retiree health benefits in both the unionized and nonunionized settings and addresses the public policy considerations for the need to further strengthen legal protections for America's aging workforce."

Hastings, Margaret M.
Financing mental health services: perspectives for the 1980s. Rockville, Md., National Institute of Mental Health, 1986. ca. 235 p. in various pagings. (U.S. Dept. of Health and Human Services. DHHS pub. no. (ADM) 86-1438)
Partial contents.--Shifting responsibility for funding mental health services and current Federal developments.--State mental health authorities.--Private perspectives.--Long term care: alternative for the future.

Hay, Joel W. Ernst, Richard L.
The economic costs of Alzheimer's disease. American journal of public health, v. 77, Sept. 1987: 1169-1175.
"The estimated present value of total net costs to society for all persons first diagnosed with Alzheimer's Disease in 1983 was $27.9--31.2 billion. Development of a public or private insurance market for the economic burdens of Alzheimer's Disease would fill some of the gaps in the current US system of financing long-term chronic disease care."

Long-term care for California's elderly: policies to deal with a costly dilemma. Berkeley, Calif., Institute of Governmental Studies, University of California, 1981. 37 p. (California Policy Seminar. Monograph no. 10)

Long-term care services for the elderly: background materials on financing and delivery of long-term care services for the elderly; a report prepared by the Congressional Research Service for the use of the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives. Washington, G.P.O., 1986. 48 p. (Print, House, 99th Congress, 2nd session, no. 99-EE)

McCallum, David. Grana, John M.
Technology becoming a growing issue in financing care. American Health Care Association journal, v. 11, Nov. 1985: 3-6.
Sees the shift in site of patient care and earlier discharges as changes which have increased the demand for nursing home and home care services. Contends that "in recent years while there has been some increased flexibility in benefits, the emphasis has been on reduced costs. Therefore, increased efficiency in extended and long term care will be necessary if the needs of a growing older population that is increasingly dependent upon technology are to be met."

Moon, Marilyn.
Private capacity to finance long term care. Washington, Urban Institute, 1983. 52 p. (Working paper 1466-12)
Partial contents.--A conceptual approach to assessing resources for financing long-term care.--Empirical results for the elderly.--Empirical results for impaired persons.--Future direction for research.

Newald, Jane.
Long-term care financing: will it bury tax reform? Hospitals, v. 61, Mar. 5, 1987: 42-48.
"Today, nearly two-thirds of those over 65 have at least one supplemental insurance policy. And most believe that Medicare alone or with supplemental insurance covers all their long-term care (LTC) medical needs, including long-term nursing home stays. It won't."

Norbeck, Timothy.
Aging America: the time bomb keeps ticking. Vital speeches of the day, v. 53, Oct. 15, 1986: 10-12.
Forsees a "bonafide crisis" concerning the elderly's financial ability to meet their health care needs. Advocates the expansion of Medicare to include catastrophic coverage and the development of insurance benefit plans that can be expanded to the elderly.

Paringer, Lynn.
The forgotten costs of informal long-term care. Washington, Urban Institute, 1983. 41 p. (Working paper 1466-28)
Partial contents.--Characteristics of the functionally disabled.--The care givers.--Allocation of time to informal care giving.--The cost of informal care.

Polich, Cynthia Longseth. Iverson, Laura Himes. Oberg, Charles N.
Who will pay?: the employer's role in financing health care for the elderly. Excelsior, Minn., InterStudy Center for Aging and Long-Term Care, c1987. 26, 7 p.

President's Private Sector Survey on Cost Control (U.S.)
Federal health care costs. Submitted to the Subcommittee for consideration at its meeting on January 15, 1984. [Washington] The Survey [1984] 65 l.
"Management Office selected issues, volume IX."
Grace Commission report, building on the reports of its Task Forces on Health and Human Services--Department Management/Human Development Services /ACTION Health and Human Services--Public Health Service/Health Care Financing Administration and Federal Hospital Management develops "recommendations that will generate savings from long-term reforms of Federal health care financing and reimbursement systems."

Private financing of long term care: current methods and resources: Phase I-II; final report. [Washington] ICF Incorporated, 1985. 2 v. (115, 70 p.)
Partial contents.--LTC Long-term care insurance.--Life, care and continuing care centers.--Single premium annuity.--LTC indemnity prototype.--Long term care IRA.--Pension benefit options.--Financial

resources of the elderly and market for LTC financing.--Home equity conversion.--Incentives to divest assets.--Impact of increased private financing on government costs.

Rappaport, Anna M. Kalman, Robert W.
The future of employer-sponsored retiree medical plans. Inquiry (Chicago), v. 24, spring 1987: 26-35.
"Complex issues cloud the economic security of people who are covered by employer-sponsored retiree medical plans. The future stability of these plans is especially confusing. In their paper, the authors carefully analyze the current structure of retiree medical plans, including the effect of certain laws. Their clarifications are objective and concise. Of particular timeliness and practicality--particularly for public policy makers--is the authors' four-point strategy to help stabilize the future."

Roper, William.
States, private sector to take the wheel: private sector to drive health policy engine. Medicare Medicaid information, v. 10, Aug. 26, 1985: 6-8.
Interview in which Dr. Roper discusses Medicare, health maintenance organizations, cost control mechanisms in health care, long-term care for the aged, Medicaid, non-profit and for-profit hospitals, and indigent medical care."

Rovner, Julie.
Long-term care: the true 'catastrophe'? Congressional Quarterly weekly report, v. 44, May 31, 1986: 1227-1231.
Examines the question of who pays for long-term care and looks at proposals to deal with these costs. The proposals include expanding Medicare coverage as well as a number of private sector initiatives.

Roybal, Edward R.
Long term care and personal impoverishment: seven in ten elderly living alone are at risk; a report presented by the Chairman of the Select Committee on Aging, House of Representatives, 100th Congress, 1st session. Washington, G.P.O., 1987. 32 p.
At head of title: Committee print.
"Comm. pub. no. 100-631"

Smeeding, Timothy M. Straub, Lavonne.
Health care financing among the elderly: who really pays the bills? Journal of health politics, policy and law, v. 12, spring 1987: 35-52.
"Investigates the issue of who pays the health care bills of the elderly by considering the types of subsidized health insurance protection enjoyed by the noninstitutionalized elderly and the way that increased Medicare cost-sharing efforts in the 1980s are affecting those without additional health insurance subsidies . . . . Found that increased cost sharing is likely to fall most heavily on those elderly least likely to afford it: the poor and near-poor elderly who have only Medicare as a health insurance subsidy, particularly those who are older and sicker and who use Medicare services more heavily."

Somers, Anne R.
Insurance for long-term care: some definitions, problems, and guidelines for action. New England journal of medicine, v. 317, July 2, 1987: 23-29.
"The costs of long-term care should and will almost certainly continue to be met through multiple sources (including personal savings, family responsibility, private insurance, and state and local assistance), but federal leadership, standards, revenue collection, and some form of coordinating framework are essential for equitable access; adequate risk pooling, income, and benefits; continuity of care and records; and avoidance of wasteful duplication."

The State of private long term care insurance: results from a national survey [June 1986]. Health Insurance Association of America research and statistical bulletin, no. 5-86, Nov. 25, 1986: 1-7.

Tell, Eileen J. Cohen, Marc A. Wallack, Stanley S.
Life care at home: a new model for financing and delivering long-term care. Inquiry (Chicago), v. 24, fall 1987: 245-252 p.
"In this paper we describe the Life Care at Home (LCAH) concept, a new long-term care insurance and service delivery model that combines the financial and health security of a continuing care retirement community (CCRC) with the freedom and independence of living at home."

U.S. Congress. House. Committee on Post Office and Civil Service. Subcommittee on Compensation and Employee Benefits.
Long term care insurance. Joint hearing before the Subcommittee on Compensation and Employee Benefits and the Subcommittee on Investigations of the Committee on Post Office and Civil Service, House of Representatives, 99th Congress, 2nd session. June 26, 1986. Washington, G.P.O., 1986. 145 p.
"Serial no. 99-68"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Long-term care. Hearing, 100th Congress, 1st session. Mar. 31, 1987. Washington, G.P.O., 1987. 220 p.
"Serial 100-19"

U.S. Congress. House. Select Committee on Aging.
Long term care and personal impoverishment: seven in ten elderly living alone at risk. Hearing, 100th Congress, 1st session. Nov. 9, 1987. Washington, G.P.O., 1988. 134 p.
"Comm. pub. no. 100-644"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
The Reagan Administration's fiscal year 1988 budget: undermining the health of older Americans; a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 100th Congress, 1st session. Washington, G.P.O., 1987. 10 p.
At head of title: Committee print.
"Comm. pub. no. 100-614"

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health.
Financing of long-term care. Hearing, 100th Congress, 1st session. June 12, 1987. Washington, G.P.O., 1988. 120 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-411)

U.S. Congress. Senate. Special Committee on Aging.
The cost of caring for the chronically ill: the case for insurance. Hearing, 98th Congress, 2nd session. Sept. 21, 1984. Washington, G.P.O., 1985. 104 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-1224)

Providing a comprehensive and compassionate long-term health care program for America's senior citizens. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 124 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-840)
"Serial no. 99-23"
Hearing held in New Haven, CT, July 7, 1986.

U.S. General Accounting Office.
Long-term care insurance: coverage varies widely in a developing market; report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. May 29, 1987. Washington, G.A.O., 1987. 52 p.
"GAO/HRD-87-80, B-226097"
"Provides information in three key areas: policy benefits and premiums, policy limitations and restrictions, and the potential for abuse in the market."

Wasilewski, Charles.
Mature customers, immature products. Best's review: life/health insurance edition, v. 87, Apr. 1987: 40-42, 44, 46.
Overviews the adequacy of and need for health insurance products which cover home care services, adult day care, nursing home care, long-term care services, and catastrophic illness. Offers the perspectives of the insurance industry, Congress, the Reagan Administration, and advocacy groups for the aged.

Wiener, Joshua M.
Private long-term care insurance: cost, coverage, and restrictions. Gerontologist, v. 27, no. 4, 1987: 487-493.
"A descriptive analysis of 31 private long-term care insurance policies was conducted. Policies were examined for premium rates, extent and levels of coverage, restrictions on eligibility to purchase a policy, and

indemnity payment levels. Findings suggested that policies are expensive, impose numerous eligibility restrictions, offer limited coverage for certain services, and provide indemnity payments that fail to account for inflation."

MEDICARE AND MEDICAID

Aiken, Linda H. Bays, Karl D.
The Medicare debate--round one. New England journal of medicine, v. 311, Nov. 1, 1984: 1196-1200.
Analyzes the diversity of views that have emerged on major options considered by the 1982-1983 Advisory Council on Social Security. These options included slowing the rate of growth in reimbursement to hospitals and physicians, advancing the age of eligibility, increasing beneficiary cost sharing, or increasing revenues.

The Attempted dismantling of the Medicare home care benefit; a report by the Chairman of the Subcommittee on Health and Long-term Care of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Washington, G.P.O., 1986. 102 p.
At head of title: Committee print.
"Comm. pub. no. 99-552"
"Released to the Subcommittee on Health and Long-Term Care at its March 19, 1986 hearing, 'Castastrophic Health Insurance: The Home Care Benefit,' by the National Association for Home Care."

Becker, Michael.
Health Care Savings Accounts: a cure for Medicare's ills. Washington, Citizens for a Sound Economy, 1986. 20 p. (CSE issue alert no. 7)
"Health Care Savings Accounts (HCSAs), would allow individuals to take a 60 percent federal income tax credit on an amount equal to Hospital Insurance payroll tax paid. Upon retirement, these funds could be used to provide health care." Examines how HCSAs would work.

Benjamin, A. E.
Determinants of State variations in home health utilization and expenditures under Medicare. Medical care, v. 24, June 1986: 535-547.
"Although Medicare is a federal program, utilization and expenditures for home care vary widely across the states . . . . Theory and data are presented that attempt to illuminate reasons why such variations exist."

Berk, Marc L. Wilensky, Gail R.
Health care of the poor elderly: supplementing Medicare. Gerontologist, v. 25, June 1985: 311-314.
"Focuses on the elderly poor and the role of both private and public insurance in supplementing Medicare. Data from the National Medical Care Expenditure Survey are used to describe the approximately 5.9 million elderly persons with incomes of less than 125% of the poverty line. Those who depend exclusively on Medicare incur substantial out-of-pocket costs, although they use much fewer services than those who also have Medicaid or private insurance."

Bonanno, James Bautz. Wetle, Terrie.
HMO enrollment of Medicare recipients: an analysis of incentives and barriers. Journal of health politics, policy and law, v. 9, spring 1984: 41-62.
"Although there has been increased interest in use of the health maintenance organization (HMO) model to resolve a variety of problems relating to provisions of health care to older individuals, less than 2 percent of Medicare beneficiaries are currently enrolled in HMOs. This paper examines both legislative and operational barriers to HMO enrollment of the elderly. Legislative reforms, HMO organizational structures, and marketing strategies thought to encourage enrollment of the elderly are discussed."

Brook, Robert H. Lohr, Kathleen N.
Monitoring quality of care in the Medicare program: two proposed systems. JAMA [Journal of the American Medical Association], v. 258, Dec. 4, 1987: 3138-3141.
Reports on research in quality assessment. "Explores how the quality

of care received by Medicare beneficiaries might be monitored so that efforts to contain expenditures do not eliminate effective, as well as ineffective, medical care."

Buchanan, Robert J.
Financing nursing home care. Human ecology forum, v. 16, winter 1987: 17-20.

Predicts that "the differences between states in payment and use rates will become wider, making concerns about quality of care in Medicaid-financed nursing homes even more acute. A possible solution would be to expand Medicare coverage to include extended nursing home stays while eliminating Medicaid coverage of long-term care."

Burwell, Brian O.
Shared obligations: public policy influences on family care for the elderly. [Rockville, Md.], U.S. Health Care Financing Administration, Office of Research and Demonstrations, 1986. 146 p. (U.S. Health Care Financing Administration, Medicaid program evaluation, working paper 2.1)

Prepared by SysteMetrics/McGraw Hill, Inc., under a subcontract with La Jolla Management Corporation.

Partial contents.--Medicaid eligibility and family caregiving.--Paging family members as medicaid providers.--Tax incentives for informal caregivers.--Required financial contributions from adult children of medicaid nursing home recipients.

Butler, Robert N.
The restructuring of Medicare: an essay on a geriatrics-based strategy for change. Journal for physicians in home care, v. 1, spring 1987: 28-32, 34-38, 40, 42.

Argues that "current government insurance programs for the elderly, such as Medicare and Medicaid, do not cover geriatric medical needs, which are quite different from those of younger adults. A National Commission on Long-Term Care should be established to explore an effective and responsive health policy for an aging America."

Candidates respond to AMA survey. American medical news, v. 31, Feb. 26, 1988: 3, 36-39.

Presidential hopefuls answer questions posed by the American Medical Association on health policies, including Medicare funding.

Clinkscale, Robert M.
Evaluation of Medicaid section 2176 home and community-based care waivers. [Rockville, Md.], U.S. Health Care Financing Administration. Office of Research and Demonstrations, 1986. 170 p. in various pagings. (U.S. Health Care Financing Administration, Medicaid program evaluation working paper 1.10)

Prepared by La Jolla Management Corporation under HCFA contract with support from SysteMetrics/McGraw-Hill, Inc.

Section 2176 of the Omnibus Budget Reconciliation Act of 1981 permits States "to expand eligibility and services beyond those normally permitted by Medicaid in order to maintain people in the community who otherwise would require Medicaid funded institutional care. In applying for waivers, States must show that the additional costs of waiver services will be offset by reductions in nursing home or other long term care Medicaid expenditures."

Committee on Aging Society (U.S.)
America's aging: health in an older society. Washington, National Academy Press, 1985. 241 p.

Partial contents.--Demographic aspects of the older population.--Waxing of the gray, waning of the green.--Active life expectancy: societal implications.--Health, disease, and cardiovascular aging.--Depressive illness in late life.--Aging and age-dependent disease: cognition and dementia.--Informal social support systems for the frail elderly.--Financing long-term care for the elderly: institutions, incentives, issues.

Conference on the Future of Medicare (1983 : Washington, D.C.)
Proceedings. Washington, G.P.O., 1984. 362 p.

At head of title: 98th Congress, 2nd session, Committee Print, no. WMCP: 98-23.

"Organized by the staff of the Committee on Ways and Means in conjunction with the Congressional Budget Office (CBO) and the Congressional Research Service (CRS)."

Davidson, Stephen M. Cromwell, Jerry. Schurman, Rachel.
Medicaid myths: trends in Medicaid expenditures and the prospects for reform. Journal of health politics, policy and law, v. 10, winter 1986: 699-728.

Article attempts to dispel eight myths concerning the Medicaid program and concludes that "given its present federal-state form and the current distribution of expenditures, it is unlikely that major reforms will be enacted because the stakes are too small for most states and the federal interest is too diffused."

Early experience of health maintenance organizations under Medicare competition demonstrations. Health care financing review, v. 8, spring 1987: 37-55.

"Between 1982 and 1985, health maintenance organizations (HMO's) entered the Medicare market under the Medicare competition demonstrations. The status and experience of these HMO's in 1984 are described . . . . Data from administrative reports, submitted by the HMO's, are used to describe the operational experience, including enrollments, utilization, and financial performance."

Effects of State Medicaid policies on the aged. Gerontologist, v. 26, Aug. 1986: 437-443.

"Changes in Medicaid policies and their effects on utilization and expenditures for the aged were reported from a descriptive study of 8 states from 1978 to 1982. States exercised greater discretionary authority by adopting cost containment policies that reduced the number eligible, the availability of services, and reimbursement rates, resulting in reductions in utilization and expenditures."

Feder, Judith. Hadley, Jack. Zuckerman, Stephen.
How did Medicare's prospective payment system affect hospitals? New England journal of medicine, v. 317, Oct. 1, 1987: 867-873.

"The study showed that hospitals paid through the prospective payment system had significantly lower increases in Medicare costs and greater declines in Medicare use than did other hospitals."

Ferrara, Peter J.
Averting the Medicare crisis: Health IRAs. Washington, Cato Institute, 1985. 13 p. (Policy analysis no. 62)

Medicare solution: the Health Bank IRA. Journal of the Institute for Socioeconomic Studies, v. 10, spring 1985: 78-87.

Contends that Medicare's financial problems can be solved by increasing "the role of the private sector in providing and financing medical care for the elderly and widening the range of consumer choice and genuine market competition and incentives" through the establishment of Health Bank IRAs.

The Future of Medicare. New England journal of medicine, v. 314, Mar. 13, 1986: 722-728.

Summary of most important proposals of the Harvard Medicare Project concludes that: "predicting the costs of all these suggested reforms in the Medicare program--some of which would not be implemented for 5 to 10 years--is difficult and hazardous. If we exclude additional long-term care benefits, we estimate that the financial impact of our proposals on Medicare expenditures in the year 2000 could range from a net saving to a net cost of approximately $3 billion (1985 dollars), depending on the assumptions used."

Harrington, Charlene. Swan, James H.
The impact of State Medicaid nursing home policies on utilization and expenditures. Inquiry (Chicago), v. 24, summer 1987: 157-172.

"Describes the extent to which Medicaid policies and other factors influence state Medicaid nursing home utilization and expenditures . . . . Focuses on three dependent variables: Medicaid nursing home recipients per 1,000 aged population, Medicaid nursing home expenditures per recipient, and total Medicaid nursing home expenditures per total aged population."

Harvard Medicare Project.
Medicare: coming of age; a proposal for reform. Cambridge, Mass., Center for Health Policy and Management, John F. Kennedy School of Government, Division of Health Policy Research and Education, 1986. 95 p.

Higgins, Linda C.
Rural care: will Congress act in time? Medical world news, v. 28, Oct. 26, 1987: 24-26, 28-29, 32-34.
"For the first time, legislative initiatives promise to offer some relief from what everyone sees as rural providers' biggest curse--DRG's rural-urban remibursement differential."

Impact of growing numbers of the very old on Medicaid expenditures for nursing homes: a multi-State, population-based analysis. American journal of public health, v. 77, June 1987: 699-703.
Uses "Medicaid data from five states which account for 39 per cent of Medicaid expenditures to study the impact of the near-trebling of persons age 85 and older (the very old) projected to occur by the year 2012 upon Medicaid nursing home expenditures." Notes that given current trends, "increasing numbers of the very old will generate an additional $6.3 billion (1982 dollars) annually of Medicaid nursing home payments by 2012."

The Initial effects of the prospective payment system on nursing home patients. American journal of public health, v. 77, July 1987: 819-821.
"Examined the discharge outcomes and admission characteristics of patients admitted to Southern California skilled nursing facilities (SNFs) for the first time following an episode of hospitalization in 1980, 1982-83 (all pre-prospective payment system), and all admissions during July through September 1984 . . . . Summarizes findings regarding case-mix and discharge outcomes observed in a specific subset of these three nursing home populations."

Interstate variation in elderly Medicaid nursing home populations. Medical care, v. 25, Aug. 1987: 738-752.
"Nursing home care in the United States is financed primarily through the federal-state Medicaid program. Because Medicaid nursing home programs are administered within the individual states, there may be interstate differences in the characteristics of Medicaid nursing home residents and their utilization of medical care. We used Medicaid claims and enrollment data for calendar 1981 from three large states--Michigan, California, and New York--to study this question."

Kinney, Eleanor D.
The Medicare appeals system for coverage and payment disputes. In Administrative Conference of the United States recommendations and reports, 1986. [Washington] The Conference [1987] p. 339-491.
"Background report for recommendation 86-5"
"In view of the restructuring of the hospital payment system in 1983 and the contemplated changes in Part B of the Medicare program, it is now especially appropriate to reexamine whether the appeals system designed and implemented in the late 1960's and early 1970's can meet the challenges posed by a significantly different health care system and Medicare program."

Klees, Barbara. Warfield, Carter.
Actuarial status and the HI and SMI Trust Funds. Social security bulletin, v. 49, July 1986: 10-18.
"Presents a summary of the current financial and actuarial status of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds. The Board found that the present financing schedule for the HI program is barely sufficient to ensure the payment of benefits through the late 1990's if the intermediate (II-A and II-B) assumptions underlying the estimates are realized."

Knickman, James R.
Insurance against impoverishment: a new policy for long-term care. New York affairs, v. 10, winter 1987: 96-107.
Recommends testing the viability of a public-private insurance system for long-term care on a demonstration basis. Asserts that New York State "needs to accomplish two related goals to alleviate the financial burden on the elderly and on government: Private insurance should assume a larger share of the costs currently paid by the elderly, and simultaneously, the growth in Medicaid costs should be curtailed."

Langley, Ann.
Medicare and the health costs of older Americans: the extent and effects of cost sharing. An information paper prepared for use by the Special Committee on Aging, U.S. Senate. Washington, G.P.O., 1984. 38 p. (Print, Senate, 98th Congress, 2nd session, committee print S. Prt. 98-166)

Laudicina, Susan S. Burwell, Brian.
A profile of Medicaid home and ocmmunity-based care waivers, 1985: findings of a national survey. Rockville, Md., U.S. Health Care Financing Administration, Office of Research and Demonstrations, 1986. 118 p.
Prepared by La Jolla Management Corp. under HCFA contract with support from SysteMetrics/McGraw-Hill, Inc.

Medicare reform: the private-sector impact. Washington, Employee Benefit Research Institute, 1985. 156 p. (EBRI-ERF policy forum)
Partial contents.--Medicare reform: what are the options?--Impact of changes in eligibility.--The impact of Medicare financing reforms: a view from the private sector.--Medigap insurance.--Federal Government supplementation of Medicare.

Medicare risk contracting: lessons from an unsuccessful demonstration. JAMA [Journal of the American Medical Association], v. 257, Feb. 6, 1987: 656-659.
"The Tax Equity and Fiscal Responsibility Act of 1982 provided a full-risk Medicare capitation financing option for health maintenance organizations and competitive medical plans. Two rounds of demonstrations were conducted, followed by the publication of final regulations in January 1985 . . . . The central reimbursement method used in Medicare risk contracting (adjusted average per capita cost) does not adequately control for enrollment selection, unmet medical need, or recent regional cost variations. Reimbursement set at 95% of estimated fee-for-service costs does not recognize, and in the long run will not support, an efficiently operating delivery system."

Meiners, Mark R. Coffey, Rosanna M.
Hospital DRGs and the need for long-term-care services: an empirical analysis. Rockville, Md., National Center for Health Services Research, 1984. 23, 6 l.
"Suggests that the DRG reimbursement system gives hospitals a strong incentive for earlier discharge of patients needing long-term-care services. However, hospitals that target only long-term-care patients for early discharge will not substantially gain under PPS because they represent a small portion of the cases treated in the hospital and a small percent of unreimbursed days."

Meyer, Jack A.
Major issues in Medicare. In Entitlement issues in the domestic budget: the long-term agenda; a conference sponsored by the American Enterprise Institute for Public Policy Research. Edited by John C. Weicher. Washington, The Institute, c1985. (AEI symposia 85B), p. 15-22.

Moon, Marilyn.
Changing the structure of Medicare benefits: issues and options. Washington, U.S. Congressional Budget Office, 1983. 82 p.
"Explores potential changes in Medicare's benefit structure. It examines options for increasing the share of medical care costs paid by beneficiaries and changes that would improve the protection of the elderly and disabled against catastrophic medical expenditures. In addition to calculating the federal savings from each options, the paper estimates the impact of such changes on individual enrollees."

Medical care transfers, poverty and the aged, by Marilyn Moon and Timothy Smeeding. Journal of health politics, policy and law, v. 6, spring 1981: 29-39.
"Explores alternative approaches to calculating the value of Medicare and Medicaid and the impact of these programs on the incidence of poverty among the aged."

National Conference on Social Welfare. Committee on Federalism and National Purpose.
To form a more perfect union: the report of the Committee on Federalism and National Purpose. Daniel J. Evans and Charles S. Robb, chairmen. Washington, Project on the Federal Social Role National Conference on Social Welfare, c1985. 52 p.
Recommends that the Federal Government establish national minimum benefit levels and eligibility standards for AFDC and Medicaid, while States retain administrative responsibility for them. Using the fiscal dividend from

federalizing these, States should assume responsibility for community development, local infrastructure, and other programs devolved to them by the Federal Government.

Passett, Barry A.
Reform Medicaid? The view from a community hospital. Forum/Health Care Financing Administration, v. 5, Oct. 1981: 30-34.
Discusses the problems of the Medicaid program and examines some proposals for addressing the problems of the health care industry. These include "using lower cost alternatives to hospital and nursing home care, paying providers according to care given, reforming long term care, and introducing price competition."

A Proposal for financing health care of the elderly, from the Board of Trustees, the Council on Medical Service, and the Council on Legislation, American Medical Association. JAMA [Journal of the American Medical Association], v. 256, Dec. 26, 1986: 3379-3382.
"The proposal would replace the pay-as-you-go financing of the current Medicare program with prefunded health expense benefits, provide for more comprehensive health expense protection, including catastrophic coverage with annual limits on out-of-pocket expense, and provide equitable means testing by relating the deductible for covered services to beneficiary income."

Prospective payment for Medicare skilled nursing facilities: background and issues. Health care financing review, v. 8, fall 1986: 79-85.
"Strong interest by Congress in a Medicare prospective payment system fo skilled nursing facilities (SNF's) resulted in a major study by the Health Care Financing Administration on the Medicare SNF benefit. This article highlights findings from that study, which addressed the following: the Medicare SNF benefit, utilization and expenditures, the Medicare SNF industry, problems with the current Medicare SNF reimbursement system, efforts to develop a Medicare SNF case-mix measure, and case-mix differences between hospital-based and freestanding SNF's."

Rolph, Elizabeth. Lindsey, Phoebe.
Medicare's prospective payment system: health care community reaction and perceptions. Santa Monica, Calif., Rand, 1986. 89 p. (R-3418-HCFA)
"Prepared for the Health Care Financing Administration, U.S. Department of Health and Human Services."
Partial contents.--The prospective payment formula and its distributive consequences.--Quality of care under prospective payment.--Effects of prospective payment on alliances and politics.

Rosenblum, Robert W.
Medicare revisited: a look through the past to the future. Journal of health politics, policy and law, v. 9, winter 1985: 669-681.
"Examines the elderly's out-of-pocket health care expenditures by category of expense, before and after the inception of Medicare. It describes the shifting of out-of-pocket expenses from hospital care to nursing-home care, while physician services and drugs have remained prominent components of out-of-pocket expenditures. Recent corrosive trends in the protection against out-of-pocket liability are discussed and analyzed."

Rowland, Diane. Lyons, Barbara.
Medicare's poor: filling the gaps in medical coverage for low-income elderly Americans. Baltimore, Commonwealth Fund Commission on Elderly People Living Alone [1987] 65 l.
"The Commission recommends that: all poor elderly people should be covered by the Medicaid program and all near-poor elderly people should have the option of purchasing Medicaid on a contributory basis."

Rozelle, Gregory J.
The effect of DRGs. Caring, v. 6, Apr. 1987: 5-9.
Examines the effect of the prospective payment system on one home care program--"the Home Health Care Program jointly sponsored by the Combined Health District and Visiting Nurses Association (CHD/VNA)."

Sager, Mark A. Leventhal, Elaine A. Easterling, Douglas V.
The impact of Medicare's prospective payment system on Wisconsin nursing homes. JAMA [Journal of the American Medical Association], v. 257, Apr. 3, 1987: 1762-1766.
"Reviewed hospitalization and mortality data for Wisconsin's Medicaid and

general elderly populations. During the 12 months following implementation of the PPS, Wisconsin's institutionalized elderly Medicaid population experienced a 72% increase in the rate of hospitalization and a 26% decline in hospital length of stay."

Schlenker, Robert E.
Case mix reimbursement for nursing homes. Journal of health politics, policy and law, v. 11, fall 1986: [illegible]5-461.
"The research reviewed in this article suggests a strong association between case mix and cost, and a weaker but still positive association between quality and cost. The research also implies that traditional nursing home reimbursement methodologies may impede access and may lower quality for Medicaid (and Medicare) recipients. To offset these problems, several states have recently begun to incorporate case mix directly into the reimbursement process. These systems deserve careful policy consideration."

Seifer, Sarena.
The impact of PPS on home health care: a survey of thirty-five home health agencies. Caring, v. 6, Apr. 1987: 10-12.
Examines changes in service, Medicare coverage, and competition since the adoption of a prospective payment system.

Shaughnessy, Peter W. Schlenker, Robert E. Polesovsky, Mary B.
Medicaid and non-Medicaid case mix differences in Colorado nursing homes. Medical care, v. 24, June 1986: 482-495.
"Profiles of case mix and related variables were compared for 1,064 Medicaid and 459 non-Medicaid residents of 65 freestanding nursing homes in Colorado in 1980. The results point to substantial case-mix differences, with Medicaid residents typically characterized by fewer and less intense long-term care problems as well as greater independence in functioning (ADLs)."

Smeeding, Timothy M. Straub, Lavonne.
Health care financing among the elderly: who really pays the bills? Journal of health politics, policy and law, v. 12, spring 1987: 35-52.
"Investigates the issue of who pays the health care bills of the elderly by considering the types of subsidized health insurance protection enjoyed by the noninstitutionalized elderly and the way that increased Medicare cost-sharing efforts in the 1980s are affecting those without additional health insurance subsidies . . . . Found that increased cost sharing is likely to fall most heavily on those elderly least likely to afford it: the poor and near-poor elderly who have only Medicare as a health insurance subsidy, particularly those who are older and sicker and who use Medicare services more heavily."

Targeting expanded care to the aged: early SHMO experience. Gerontologist, v. 28, Feb. 1988: 4-17.
Walter Leutz and others assess social health maintenance organizations which deliver integrated, prepaid, acute, and chronic care to Medicare beneficiaries as part of a national demonstration program.

U.S. Congress. House. Committee on Energy and Commerce.
Medicare and Medicaid Patient and Program Protection Act of 1987; report to accompany H.R. 1444 . . . including cost estimate of the Congressional Budget Office. Washington G.P.O., 1987. 65 p. (Report, House, 100th Congress, 1st session, no. 100-85, part 1)

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Deficit reduction proposals affecting Medicare. Hearing, 99th Congress, 2nd session on H.R. 3260, H.R. 4638, H.R. 4797, H.R. 4881 and H.R. 5146. July 16, 1986. Washington, G.P.O., 1987. 317 p.
"Serial no. 99-161"

Health care for the elderly. Hearing, 99th Congress, 2nd session. Mar. 26, 1986. Washington, G.P.O., 1987. 129 p.
"Serial no. 99-139"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Long-term care. Hearing, 100th Congress, 1st session. Mar. 31, 1987. Washington, G.P.O., 1987. 220 p.
"Serial 100-19"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-term Care.
Problems of the elderly: Central States Coalition on Aging. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1987. 97 p.
Hearing held Aug. 9, 1986 in Kansas City Mo.
"Comm. pub. no. 99-609"

The Reagan Administration's fiscal year 1988 budget: undermining the health of older Americans; a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 100th Congress, 1st session. Washington, G.P.O., 1987. 10 p.
At head of title: Committee print.
"Comm. pub. no. 100-614"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment.
Medicare DRG's long-term care: effect on retirement income security. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1985. 105 p.
Hearing held on June 17, 1985 at Montelier, Vt.
"Comm. pub. no. 99-524"

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health.
Medicare and Medicaid. Hearing, 100th Congress, 1st session. Jan. 29, 1987. Washington, G.P.O., 1987. 197 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-19)

U.S. Congress. Senate. Committee on Governmental Affairs. Subcommittee on Intergovernmental Relations.
Comprehensive Federalism reform. Hearing, 99th Congress, 2nd session. Sept. 26, 1986. Washington, G.P.O., 1986. 329 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-906)
Includes testimony and materials on S. 2926, the Federalism Act of 1986, which proposes reforms of the AFDC and Medicaid programs.

U.S. Congress. Senate. Committee on the Budget.
Concurrent resolution on the budget for fiscal year 1988. Vol. III of IV. Hearings, 100th Congress, 1st session. Washington, G.P.O., 1987. 352 p. (Hearings, Senate, 100th Congress, 1st session, S. Hrg. 100-68, Vol. III)
Human resources: Medicare, Medicaid, catastrophic health, welfare reform; Jan. 22; Feb. 25, 1987; Education policy: views of the Secretary of Education, Jan. 14, 1987; Outside education experts--Feb. 17, 1987.

U.S. Congress. Senate. Special Committee on Aging.
Prescription drugs and the elderly: the high cost of growing old. Hearing, 100th Congress, 1st session. July 20, 1987. Washington, G.P.O., 1987. 168 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-297)
"Serial no. 100-9"

The proposed fiscal year 1988 budget: what it means for older Americans. Hearing, 100th Congress, 1st session. Mar. 13, 1987. Washington, G.P.O., 1987. 468 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-113)
"Serial no. 100-3"

U.S. General Accounting Office.
Medicaid and nursing home care: cost increases and the need for services are creating problems for the States and the elderly; report to the Chairman of the Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives. Washington, G.A.O., 1983. 172 p.
"GAO/IPE-84-1, Oct. 21, 1983"
"Nursing home care for the elderly is the most expensive of the long-term health care services, and Medicaid is the largest single payer for this care. Medicare and private insurance pay for a negligible portion. Because the catastrophic costs of long-term institutional care often exceed the financial resources of the elderly, the Federal and State Governments share the responsibility for insuring that Medicaid provides adequate and efficient nursing home care to the people who need it but cannot pay for it."

Medicaid: determining cost-effectiveness of home and community-based service; report to the administrator, Health Care Financing Administration, Department of Health and Human Services. Apr. 28, 1987. Washington, G.A.O., 1987. 20 p.

"GAO/HRD-87-61, B-208492"

"While HCFA's revised reporting requirements should improve the accuracy of states' program information GAO recommends that HCFA develop information on the extent to which the program prevents or postpones the need for nursing home care. Without such information, the program's cost-effectiveness cannot be adequately evaluated."

Medicare and Medicaid: effects of recent legislation on program and beneficiary costs; report to the Chairman, Select Committee on Aging, House of Representatives. Apr. 8, 1987. Washington, G.A.O., 1987. 54 p.

"GAO/HRD-87-53, B-226390"

"Discusses the effects of major legislation since 1980 on Medicare and Medicaid program costs and on beneficiary out-of-pocket costs."

Medicare: need to strengthen home health care payment controls and address unmet needs; report to the Chairman, Special Committee on Aging. Dec. 1986. Washington, G.A.O., 1986. 66 p.

"GAO/HRD-87-9"

"This report on the Medicare home health program covers three broad themes--the effectiveness of program controls, the characteristics of home health users, and the extent of unmet home care needs reported by a sample of chronically ill elderly."

Medicare: preliminary strategies for assessing quality of care; briefing report to the chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives. July 10, 1987. Washington, G.A.O., 1987. 54 p.

"GAO/PEMD-87-15BR, B-226412"

"Examines options for short-term improvements in the measurement of quality of care in the Medicare program and develops recommendations for long-term efforts regarding the program's assessment."

Post-hospital care: efforts to evaluate Medicare prospective payment effects are insufficient; report to the Chairman, Special Committee on Aging, U.S. Senate. June 2, 1986. Washington, GAO, 1986. 174 p.

"GAO/PEMD-86-10; B-217732"

GAO recommends that more information be developed "on the effects of prospective payment on the use and expenditures for post-hospital skilled nursing home and home health care services, and on readmissions to Medicare-covered facilities and mortality rates for episodes of illness beginning with a hospitalization."

U.S. Prospective Payment Assessment Commission.

Medicare prospective payment and the American health care system; report to the Congress, Feb. 1987. Washington, The Commission, 1987. 117 p.

Partial contents.--Health expenditures.--Use and provision of hospital services and hospital financial condition.--Selected distributional aspects of PPS on hospitals.--Financial effects of PPS on beneficiaries.--Financing and delivery of health care services.--Issues emerging from changes in the health care system.

Weissert, William G.

Hard choices: targeting long-term care to the "at risk" aged. Journal of health, politics, policy and law, v. 11, fall 1986: 463-481.

"Recent expansion of Medicaid coverage to home- and community-based long-term care moves that payment program away from its traditional institutional bias. But tension over the appropriate role of home care and fears of budget-busting have caused the current administration to set goals for the states that may be impossible to achieve."

Whitcomb, Michael E.

Health care for the poor: a public-policy imperative. New England journal of medicine, v. 315, Nov. 6, 1986: 1220-1222.

"Because advocates for the poor are a weaker political force than advocates for the elderly, a compromise solution at the federal level would certainly be to the relative disadvantage of the poor. The author suggests, therefore, that the responsibilities for providing health care for the poor and long-term care for the elderly be delegated to different levels of government."

CATASTROPHIC HEALTH INSURANCE

Bowen, Otis R. Burke, Thomas R.
Cost neutral catastrophic care proposed for Medicare recipients. FAH [Federation of American Hospitals] review, Nov.-Dec. 1985: 42-45.
"Outlines a proposal for restructuring the Medicare benefit package in a manner that will provide catastrophic acute inpatient and outpatient care to Medicare beneficiaries in a cost neutral manner."

Background materials on health care coverage and expenses of the Medicare population including H.R. 1280/H.R. 1281, the Medicare Catastrophic Protection Acts of 1987. Washington, G.P.O., 1987. 67 p.
At head of title: 100th Congress, 1st session, Committee print, WMCP: 100-10.

Brody, Stanley J.
Strategic planning: the catastrophic approach. Gerontologist, v. 27, Apr. 1987: 131-138.
"Three major societal responses to the perceptions of catastrophe for the aging family are traced. The first two, the needs for basic subsistence and for access to acute care medicine, were resolved . . . . The third and unresolved catastrophe, the need for continuity of care, is defined, popular perceptions of that need evaluated, and a policy solution suggested."

Burke, Karen A.
Catastrophic health care kit. Washington, Republican Study Committee, 1987. 6 p.
"Designed to help Members determine what their elderly constituents think about HR 2470/2941, and how they might want their Member to vote should the President veto the bill."

Catastrophic insurance. Perspectives, Apr. 21, 1986: whole issue (4 p.)
Concludes that "public debate may generate political support for catastrophic health insurance, but changes in the American health system will be limited. Comprehensive health plans that increase government spending face an uncertain future."

Ferrara, Peter J.
Controlling catastrophic health costs: Otis Bowen's grand opportunity. Washington, Heritage Foundation, 1986. 11 p. (Backgrounder no. 499)
Argues that "the catastrophic insurance study now underway is a key test for Otis Bowen. The Medicare expansion plan being urged by some of Bowen's staff contradicts Ronald Reagan's overall philosophy of greater reliance on the private sector."

Making catastrophic health care affordable: a nine point program, by Peter J. Ferrara and Stuart Butler. Washington, Heritage Foundation, 1987. 13 p. (Backgrounder no. 563)
Describes a nine point program that would include changing "the law governing private policies supplementing Medicare to require insurance companies marketing policies to provide catastrophic hospital coverage," providing "vouchers through Medicare to assist the elderly to purchase private catastrophic insurance policies,' and establishing "'Health Banks' to encourage workers to obtain inexpensive catastrophic coverage and save for their out-of-pocket health care costs."

Fuchs, Beth C. Hoadley, John F.
Reflections from inside the Beltway: how Congress and the President grapple with health policy. PS, v. 20, spring 1987: 212-220.
Presents "an account of how one issue--catastrophic health insurance--reached the political agenda and then more general comments on how health legislation has been considered and passed in recent years, with particular emphasis on the use of the budget reconciliation process."

Hook, Janet.
Catastrophic insurance for all. Washington monthly, v. 19, Feb. 1987: 37-40.
Examines the arguments against providing catastrophic health insurance.

Norbeck, Timothy.
Aging America: the time bomb keeps ticking. Vital speeches of the day, v. 53, Oct. 15, 1986: 10-12.
Forsees a "bonafide crisis" concerning the elderly's financial ability to meet their health care needs. Advocates the expansion of Medicare to include catastrophic coverage and the development of insurance benefit plans that can be expanded to the elderly.

Rice, Thomas. Gabel, Jon.
Protecting the elderly against high health care costs. Health affairs, v. 5, fall 1986: 5-21.
"Analyzes the health care utilization patterns of the elderly to determine the extent to which current Medicare and Medigap policies pay for high-cost illnesses. Then examines the out-of-pocket burden that remains and explores what types of additional coverage can reduce the chance of catastrophic financial losses. The findings are used to suggest ways in which the federal government can most effectively extend health care coverage for high-cost illnesses."

U.S. Congress. House. Committee on Energy and Commerce.
Medicare Catastrophic Protection Act of 1987; report together with dissenting views to accompany H.R. 2470 . . . including cost estimate of the Congressional Budget Office. Washington, G.P.O. 1987. 153 p. (Report, House, 100th Congress, 1st session, no. 100-105, part 2)

U.S. Congress. House. Committee on Post Office and Civil Service. Subcommittee on Compensation and Employee Benefits.
Medicare Catastrophic Protection Act. Hearing, 100th Congress, 1st session. Oct. 7, 1987. Washington, G.P.O., 1987. 201 p.
"Serial no. 100-27"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.
Catastrophic coverage under Medicare. Hearing, 99th Congress, 2nd session. Feb. 25, 1986. Washington, G.P.O., 1986. 264 p.
"Serial 99-55"

Catastrophic illness expenses. Hearings, 100th Congress, 1st session. Washington, G.P.O., 1987. 578 p.
Hearings held Jan. 29-Mar. 30, 1987.
"Serial 100-7"

U.S. Congress. House. Select Committee on Aging.
Catastrophic health costs: broad problem demanding equally broad solution. Joint hearing before Select Committee on Aging, House of Representatives and the Special Committee on Aging, United States Senate, 100th Congress, 1st session. Jan. 28, 1987. Washington, G.P.O., 1987. 2 v. (102, 40 p.)
"House Select Committee on Aging pub. nbr. 100-618 and 100-623; Senate Sepcial Committee on Aging pub. nbr. 100-2"

Catastrophic health insurance: a New Jersey perspective. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 76 p.
"Comm. pub. no. 100-625"
Hearing held Apr. 10, 1987, Elizabeth, NJ.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Catastrophic health care coverage: mending a broken promise. Hearing, 99th Congress, 2nd session. Feb. 19, 1986. Washington, G.P.O., 1986. 90 p.
"Comm. pub. no. 99-565"

Catastrophic health insurance: filling the long-term care gap. Hearing, 100th Congress, 1st session. July 2, 1987. Washington, G.P.O., 1987. 107 p.
"Comm. pub. no. 100-632"

Catastrophic health insurance: the home care benefit. Hearing, 99th Congress, 2nd session. Mar. 19, 1986. Washington, G.P.O., 1986. 96 p.
"Comm. pub. no. 99-562"

Catastrophic health insurance: the Medigap crisis. Hearing, 99th Congress, 2nd session. June 25, 1986. Washington, G.P.O., 1986. 271 p.
"Comm. pub. no. 99-587"

Catastrophic health insurance: the "medigap" crisis; a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Washington, G.P.O., 1986. 278 p.
At head of title: Committee print.
"Comm. pub. no. 99-576"

Catastrophic health insurance: the New Jersey and New York perspective. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 70 p.
Hearing held May 11, 1987, Newark, NJ.
"Comm. pub. no. 100-630"

Catastrophic health insurance: the Pennsylvania perspective. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 41 p.
Hearing held Apr. 10, 1987, Philadelphia, PA.
"Comm. pub. no. 100-624"

Catastrophic health insurance: the Tennessee perspective. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 52 p.
Hearing held Mar. 27, 1986 in Chattanooga, Tenn.
"Comm. pub. no. 99-566"

Catastrophic insurance: how the Bowen plan fails. Hearing, 100th Congress, 1st session. Feb. 17, 1987. Washington, G.P.O., 1987. 116 p.
"Comm. pub. no. 100-615"

Paying the price of catastrophic illness: from accidents to Alzheimer's. Hearing, 100th Congress, 1st session. Jan. 28, 1987. Washington, G.P.O., 1987. 176 p.
"Comm. pub. no. 100-616"

Paying the price of catastrophic illness: from accidents to Alzheimer's. Washington, G.P.O., 1987. 58 p.
At head of title: Committee print.
"Comm. pub. no. 100-612"

U.S. Congress. Senate. Committee on Finance.
Catastrophic health insurance. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 3 v. (122, 204, 235 p.) (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-169, pt. 3)
Hearings held Jan. 28, Mar. 19, and Mar. 26, 1987.

Medicare Catastrophic Loss Prevention Act of 1987; report to accompany S. 1127. Washington, G.P.O. 1987. 83 p. (Report, Senate, 100th Congress, 1st session, no. 100-126)

U.S. Congress. Senate. Special Committee on Aging.
Catastrophic health care costs. Hearing, 100th Congress, 1st session. Jan. 26, 1987. Washington, G.P.O., 1987. 199 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-69)
"Serial no. 100-1"

The catastrophic state of catastrophic health care coverage. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 208 p.
Hearing held in Birmingham, AL, Apr. 16, 1987.
"Serial no. 100-4"

Health care for older Americans: insuring against catastrophic loss. Hearings, 99th Congress, 2nd session. Washington, G.P.O., 1987. 160 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-991)
"Serial no. 99-26"
"Hearings on Part 1--Fort Smith, AR, Aug. 27, 1986; Part 2--Little Rock, AR, Aug. 28, 1986.

U.S. Dept. of Health and Human Services.
Catastrophic illness expenses; report to the President. Washington, The Department, 1986. 117 p.
Partial contents.--The current health care system and the problem of catastrophic expenses.--Coverage and risk patterns: acute care for the elderly.--Long term care for the elderly.--Coverage and risk patterns: the working age population.--Catastrophic illness coverage policy options.--More complete coverage of catastrophic illness expense for Americans: recommended strategy.

U.S. General Accounting Office.
Medicare: comparison of catastrophic health insurance proposals--an update; briefing report to the Chairman, Select Committee on Aging, House of Representatives. Oct. 16, 1987. Washington, G.A.O., 1987. 44 p.
"GAO/HRD-88-19BR, B-226390"
Updates a "report comparing Medicare catastrophic health insurance proposals to include H.R. 2470, as passed by the House on July 22, 1987 and S. 1127, as reported by the Senate Committee on Finance on July 27, 1987."

Medicare: comparison of catastrophic health insurance proposals; briefing report to the chairman, Select Committee on Aging, House of Representatives. June 19, 1987. Washington, G.A.O., 1987. 38 p.
"GAO/HRD-87-92BR, B-226390"
"Focuses on legislative proposals to provide catastrophic coverage to Medicare beneficiaries."

U.S. President (1981- : Reagan)
Proposed legislation--"Medicare Catastrophic Illness Coverage Act"; message from the President of the United States transmitting a draft of proposed legislation to provide for Medicare Catastrophic Illness Coverage and for other purposes. Washington, G.P.O., 1987. 8 p. (Document, House, 100th Congress, 1st session, no. 100-36)

OLDER AMERICANS ACT

Binstock, Robert H.
Title III of the Older Americans Act: an analysis and proposal for the 1987 reauthorization. Gerontologist, v. 27, June 1987: 259-265.
"Considered here are the present and future roles of the Aging Services Network that is funded by Title III of the Act. Also discussed are the accomplishments, historical evolution, and current dilemmas of the Network. Various policy options are analyzed. And a proposal is made for amending Title III to establish a nationwide network of Aging Resource Centers for Help (ARCHs)."

Compilation of the Older Americans Act of 1965 and related provisions of law as amended through September 30, 1985. Prepared for use by the Committee on Education and Labor, U.S. House of Representatives. Washington, G.P.O., 1986. 78 p.
At head of title: 99th Congress, 2nd session. Committee print.
"Serial no. 99-H"

Cutler, Neal E.
Federal and State responsibilities and the targeting of resources within the Older Americans Act: the dynamics of multiple agenda-setting. Policy studies journal, v. 13, Sept. 1984: 185-196.
"Focuses on the agenda setting dynamics of targeting within the Older

Americans Act. Examines the evolution of the 'greatest economic or social need' mandate at the federal level, looking first at the legislative and second at the regulatory politics involved."

Nutrition programs for senior Americans: an action guide. Washington, Food Research and Action Center [1984] 32 p.
Outlines provisions of the Older Americans Act which enable community organizations to create and maintain programs to provide nutritious meals to older people. Describes the role of State and local agencies.

OAA, 1965-1985, 20th anniversary: an orientation to the Older Americans Act. Rev. ed. Edited by Susan Coombs Ficke. Washington, National Association of State Units on Aging, 1985. 122 p .
Partial contents.--Historical overview.--Implementing Title III: grants for State and community programs on aging.--The Federal legislative process and the making of aging policy.--Influences and role of national interest groups in the aging field.--Glossary.
Out of print, Mar. 1988.

Older Americans Act: a staff summary by the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, Ninety-eighth Congress, second session. Washington, G.P.O., 1985. 164 p.
At head of title: committee print.
Prepared with the assistance of the Congressional Research Service.
Comm. pub. no. 98-482

O'Shaughnessy, Carol
Older Americans Act Amendments of 1987: a summary of provisions, Public law 100-175; an information paper prepared for use by the Special Committee on Aging, United States Senate. Washington, G.P.O., 1987. 89 p.
"Serial no. 100-C"
At head of title: "100th Congress, 1st session. Committee Print, S. prt. 100-68."

Schneider, Robert L.
Barriers to effective outreach in title VII nutrition programs. Gerontologist, v. 19, Apr. 1979: 163-168.
"In 1972, Congress enacted the Nutrition Act under Title VII of the Older Americans Act in order to initiate a new national policy which would provide older Americans, particularly those with low incomes, with nutritionally sound meals served in strategically located community centers. There is little evidence that Title VII outreach efforts actually identifies, informs, and persuades the neediest elderly to participate."

U.S. Congress. House. Committee on Education and Labor. Subcommittee on Human Resources.
Older Americans Act amendments of 1984. Hearing, 98th Congress, 2nd session on H.R. 4785. Mar. 15, 1984. Washington, G.P.O., 1985. 564 p.

Reauthorization hearings on the Older Americans Act. Hearings, 100th Congress, 1st session. Washington, G.P.O., 1987. 2 v. (510, 407 p.)
"Serial no. 100-18, 19"

U.S. Congress. House. Select Committee on Aging.
California concerns regarding reauthorization of the Older Americans Act: 1984. Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 159 p.
"Comm. pub. no. 98-437"
Hearing held Nov. 28, 1983, Los Angeles, Calif.

Reauthorization issues for the Older Americans Act. Joint hearing before the Select Committee on Aging and the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, 98th Congress, 2nd session. Feb. 21, 1984. Washington, G.P.O., 1984. 306 p.
"Comm. pub. no. 98-446"

Reauthorization of the Older Americans Act. Vol. I. Joint hearing before the Select Committee on Aging and the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Sept. 16, 1986. Washington, G.P.O., 1986. 118 p.
"Comm. pub. no. 99-601"

Reauthorization of the Older Americans Act: New Jersey perspective. Hearing, 98th Congress, 2nd session. Mar. 19, 1984. Washington, G.P.O., 1985. 99 p.
Hearing held in Elizabeth, N.J.
"Comm. pub. no. 98-494"

Reauthorization of the Older Americans Act: the plight of the underserved. Hearing, 100th Congress, 1st session. Mar. 25, 1987. Washington, G.P.O., 1987. 112 p.
"Comm. pub. no. 100-619"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
The Older Americans Act: a questionnaire on congregate and home-delivered meals under title III. Washington, G.P.O., 1983. 7 p.
At head of title: Committee print.

Problems of the elderly: Central States Coalition on Aging. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1987. 97 p.
Hearing held Aug. 9, 1986 in Kansas City Mo.
"Comm. pub. no. 99-609"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Human Services.
A compendium of papers honoring the twentieth anniversary of the Older Americans Act; a background paper, 99th Congress, 1st session. Washington, G.P.O., 1985. 106 p.
At head of title: Committee print.
"Comm. pub. no. 99-525"

The Older Americans Act and the fiscal year 1984 budget. Hearings, 98th Congress, 1st session. Feb. 23 and Mar. 1, 1983. Washington, G.P.O., 1983. 215 p.
"Comm. pub. no. 98-377"

Older Americans Act programs: Houghton Lake, MI. Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 54 p.
Hearing held in Houghton Lake, Mich., Oct. 10, 1983.
"Comm. pub. no. 98-456"

Older Americans Act nutrition program. Hearing, 99th Congress, 2nd session. July 30, 1986. Washington, G.P.O., 1986. 22 p.
"Comm. pub. no. 99-586"

Reauthorization of the Older Americans Act. Hearing, 99th Congress, 2nd session. Vol. III. Dec. 15, 1986. Washington, G.P.O., 1987. 52 p.
Hearing held in New York, NY.
"Comm. pub. no. 99-608"

Reauthorization of the Older Americans Act: legal services for the elderly. Hearing, 100th Congress, 1st session. Vol. 4. Jan. 27, 1987. Washington, G.P.O., 1987. 138 p.
"Comm. pub. no. 100-613"

Reauthorization of the Older Americans Act: the California experience. Hearing, 99th Congress, 2nd session. Volume II. Washington, G.P.O., 1987. 59 p.
"Comm. pub. no. 99-605"
Hearing held in San Carlos, CA, Oct. 22, 1986.

Regulations to implement the Older Americans Act Amendments of 1984. Hearings, 99th Congress, 1st session. Washington, G.P.O., 1985. 191 p.
"Comm. pub. no. 99-510"
Hearings held Mar. 14 and Apr. 25, 1985.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Retirement Income and Employment.
Reauthorization of the Older Americans Act: a rural perspective. Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 335 p.
Hearing held in Roseville, Calif., Dec. 2, 1983.
"Comm. pub. no.98-433"

U.S. Congress. Senate. Committee on Labor and Human Resources.
Judicial access and the elderly. Hearing, 98th Congress, 1st session. July 12, 1983. Washington, G.P.O., 1983. 141 p. (Hearing, Senate, 98th Congress, 1st session, S. Hrg. 98-437)

Older Americans Act amendments of 1987; report to accompany S. 887. Washington, G.P.O. 1987. 157 p. (Report, Senate, 100th Congress, 1st session, no. 100-136)

U.S. Congress. Senate. Committee on Labor and Human Resources. Subcommittee on Aging.
Older Americans Act of 1987. Hearings, 100th Congress, 1st session on S. 887. Washington, G.P.O., 1987. 823 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-196)
Hearings held Mar. 31, Apr. 23, and 30, 1987.

Reauthorization of the Older Americans Act. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 204 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-941)

Older Veterans and the Older Americans Act. Hearing, 98th Congress, 1st session. Oct. 20, 1983. Washington, G.P.O., 1983. 201 p. (Hearings, Senate, 98th Congress, 1st session, S. Hrg. 98-436)

Targeting scarce resources under the Older Americans Act. Hearing, 98th Congress, 1st session. Nov. 15, 1983. Washington, G.P.O., 1984. 289 p. (Hearing, Senate, 98th Congress, 1st session, S. Hrg. 98-684)

U.S. Congress. Senate. Special Committee on Aging.
The Older Americans Act and its application to Native Americans. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 210 p. (Hearing, Senate, 99th Congress, 2nd session, S. Hrg. 99-827)
Hearing held in Oklahoma City on June 28, 1986.
Three panels discuss the sensitivity of the Administration on Aging to Native Americans, the coordination of services between title III and title VI of the Older Americans Act, and the availability of services under the act.

Reauthorization of the Older Americans Act. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 35 p. (Hearing, Senate, 100th Congress, 1st session, S. hrg. 100-442)
"Serial no. 100-8"
Hearing held in Casselberry, FL, July 2, 1987.

U.S. Federal Council on Aging.
Toward more effective implementation of the Older Americans Act. Washington, 1981. 116 p. (U.S. Dept. of Health and Human services. DHHS publication no. (OHDS) 81-20305)
Partial contents.--Evaluating Older Americans Act programs.--AoA's roles in advocacy.--Fundamental purpose of grants for state and community programs on aging.--Senior community service employment.--Low-income and minority participation in AoA programs.

NURSING HOMES: USE, REGULATION, AND QUALITY CONTROL

Assuring the quality of health care for older persons: an expert panel's priorities. JAMA [Journal of the American Medical Association], v. 258, Oct. 9, 1987: 1905-1908.

A panel of physicians and quality assurance experts rated the relative needs and merits of intervention to improve quality. "Using the ratings, the conditions selected for quality assurance work were congestive heart failure, hypertension, pneumonia, breast cancer, adverse effects of drugs, incontinence, and depression." Evaluations are included of long-term-care facilities (intermediate-care facilities and skilled nursing facilities), home health care services, and case management.

Butler, Patricia A.
Assuring the quality of care and life in nursing homes: the dilemma of enforcement. North Carolina law review, v. 57, Aug. 1979: 1317-1382.

Article looks at "some possible means by which regulating agencies and the public, including nursing home residents themselves, can improve the quality of nursing home care." Discusses some of the legal, political, and practical difficulties they face in attempting to do so.

Caldwell, Jancie M. Kapp, Marshall B.
The rights of nursing home patients: possibilities and limitations of Federal regulation. Journal of health politics, policy and law, v. 6, spring 1981: 40-48.

"Using as their point of departure the proposed nursing home standards recently published by the U.S. Department of Health and Human Services, the authors discuss the dilemma of regulating for human rights. Provisions considered for inclusion in the regulations are discussed in light of positions taken by regulators, providers and consumers. By highlighting the trade-offs involved, the authors point out the limitations of regulation in this emotion-laden area."

Cohen, Marc A. Tell, Eileen J. Wallack, Stanley S.
The lifetime risks and costs of nursing home use among the elderly. Medical care, v. 24, Dec. 1986: 1161-1172.

"Estimates the risk of an individual entering a nursing home throughout the aging process and estimates the expected lifetime costs of nursing home use both for an individual and for society as a whole . . . . The risk of entering a nursing home increases with age until around age 80. At about age 85, the risk begins to decline significantly."

Friedman, Bernard.
Economic aspects of the rationing of nursing home beds. Journal of human resources, v. 17, winter 1982: 59-71.

"State governments, with federal subsidies under the Medicaid program, are the source of the largest share of expenditures to support patients in the long-term institutional nursing care. A major state policy tool that has been evolving is the authority to approve or deny expansions in bed capacity."

Gentile, Benedict. Mistarz, Jo Ellen.
Nursing home market attracts multis: survey. Hospitals, v. 59, June 1, 1985: M24-M26.

"Multihospital systems already have a foothold in the nursing home market, and they expect their holdings in that market to increase. But few are active in the lifecare and/or continuing care retirement markets, and multis appear hesitant to embark into that area."

Gertler, Paul J.
Subsidies, quality, and regulation in the nursing home industry. Cambridge, Mass., National Bureau of Economic Research, 1985. 29 p. (Working paper no. 1691)

"Analyzes the impact of the Medicaid patient subsidy and Certificate of Need (CON) cost containment programs on nursing home behavior. . .. Analysis shows that CON policy makers are forced to trade off containing the size of the industry (and therefore total Medicaid payments) against quality and access of the poor to nursing home care. Specifically, finds that the capacity constraints and the reduced competition from the entry barriers lead to lower quality and fewer Medicaid patients receiving care."

Hawes, Catherine.
Nursing home reform and the politics of long-term care. PS, v. 20, spring 1987: 232-241.
Discusses problems in regulation of the quality of care given in nursing homes. Argues that both Federal and State "long-term care policy has been shaped in a political environment dominated by nursing home owners. Their fundamental goal has been to minimize regulation and maximize reimbursement from Medicare and Medicaid."

Hing, Esther.
Use of nursing homes by the elderly: preliminary data from the 1985 National Nursing Home Survey. NCHS [National Center for Health Statistics] advancedata, no. 135, May 14, 1987: 1-12.

Institute of Medicine (U.S.). Committee on Nursing Home Regulation.
Improving the quality of care in nursing homes. Washington, National Academy Press, 1986. 415 p.
Reports on "a study of government regulation of nursing homes (excluding intermediate care facilities for the mentally retarded). The study's purpose was to recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care."

Jones, Brenda J. Meiners, Mark R.
Nursing home discharges: the results of an incentive reimbursement experiment. Rockville, Md., National Center for Health Services Research, 1986. 11 p. (U.S. Dept. of Health and Human Services. DHHS publication (PHS) 86-3399)
At head of title: Health Care for the Aging.
"Long-term Care Studies Program Research Report"
"Presents findings from a major demonstration and evaluation project which studied the consequences of using incentive payments to change admission, discharge and outcome patterns for Medicaid patients in nursing homes."

Kane, Robert L. Matthias, Ruth.
From hospital to nursing home: the long-term care connection. Gerontologist, v. 24, Dec. 1984: 604-609.
"Reports on efforts to develop a statistical model to predict which patients admitted to the hospital from home will be discharged to a nursing home. The findings have implications for the discharge planning role."

Keeler, Emmett B. Kane, Robert L. Solomon, David H.
Short- and long-term residents of nursing homes. Medical care, v. 19, Mar. 1981: 363-369.
"Analyzes reported data on length of stay of discharged patients from the 1977 National Nursing Home Survey."

Kemanis, Vija.
A critical evaluation of the Federal role in nursing home quality enforcement. Colorado law review, v. 51, summer 1980: 607-640.
Comment examines the Federal role in nursing home regulation and enforcement and looks at the extent to which the Dept. of Health and Human Services meets its statutory duty to provide high quality nursing home care. It explores the Federal-state relationship under Medicare and Medicaid and explains how the system restricts the states' options for improving care.

Litwin, Howard. Kaye, Lenard W. Monk, Abraham.
Conflicting orientations to patient advocacy in long-term care. Gerontologist, v. 24, June 1984: 275-279.
"Analysis of national survey data on nursing home ombudsman programs documents three alternative formulation of advocacy subscribed to by constituent groups in the long-term care network: individualized/developmentally-focused, individualized/patients' rights-focused, and facility/patients' rights-focused."

Liu, Korbin. Manton, Kenneth G.
The length-of-stay pattern of nursing home admissions. Medical care, v. 21, Dec. 1983: 1211-1222.
Estimates "that the typical nursing home admission initially has an expected LOS length of stay of 456 days, but, more interesting the remaining LOS is expected to increase, in the intermediate term, with the amount of time spent in the facility."

McConnel, Charles E.
A note on the lifetime risk of nursing home residency. Gerontologist, v. 24, Apr. 1984: 193-198.
"The widely accepted estimate that an elderly individual faces a 25% risk of institutionalization in a long-term care facility is assessed. Measures that rely on death certificates to establish nursing home residency are shown to lead to an unacceptable level of error in accounting for utilization. Using national data and a life table method of estimation, it is shown that the elderly individual's risk of institutional approaches and may exceed 50%."

Mental illness in nursing homes: agenda for research. Edited by Mary S. Harper and Barry D. Lebowitz. Rockville, Md., National Institute of Mental Health, 1986. 355, 30, 3 p.

Miller, James L.
An evaluation of regulatory standards and enforcement devices in the nursing home industry. Akron law review, v. 13, spring 1980: 715-729.
Comment describes the economic structure of the nursing home industry, explores current regulatory standards and enforcement devices which have been developed by Federal agencies, and examines Ohio legislation "which not only confers various rights upon nursing home residents but also seeks to eliminate institutional abuse through the implementation of adaptive enforcement devices."

Mitchell, Janet B. Hewes, Helene T.
Why won't physicians make nursing home visits? Gerontologist, v. 26, Dec. 1986: 650-654.
"The majority of physicians will not visit nursing home patients, but only anecdotal evidence has been available on why this is the case. As part of a survey of Michigan physicians, respondents were asked whether they made nursing home visits and if not, why not. A typology was developed to differentiate among various physician types based on reasons given. Six physician types were found, each identified with a different policy lever that could be used to encourage them to treat nursing home patients."

Mor, Vincent. Sherwood, Sylvia. Gutkin, Claire.
A national study of residential care for the aged. Gerontologist, v. 26, Aug. 1986: 405-417.
"A national survey of Residential Care Home (RCH) programs and a 5-state survey of RCHs and the elderly they serve revealed that in 1980 there were 118 RCH programs regulating 29,282 facilities serving some elderly with a total 371,734 beds. Most facilities were family owned and operated."

Nyman, John A.
Improving the quality of nursing homes: regulation or competition? Journal of policy analysis and management, v. 6, winter 1987: 247-251.
Discusses demand for nursing home beds. "Use of hospital beds is dropping, and many hospitals are converting some space to long-term care; but even if every empty hospital bed became a nursing bed, 450,000 new places would be needed . . . . The bed shortage hurts the quality of care provided because it greatly reduces homes' need to compete for patients, especially public patients."

Organizing an academic nursing home: impacts on institutionalized elderly. JAMA [Journal of the American Medical Association], v. 255, May 16, 1986: 2622-2627.
"Beneficial developments associated with the program in concurrent comparison with the standard nursing home unit included a significant decrease in patient transfers to the acute-care hospital and significant improvements in functional status, patient satisfaction, and morale . . . . Longer-term follow-up revealed a significantly increased rate of discharge for patients completing long-term rehabilitation. Overall, the costs of nursing home care were only minimally increased by the program. Results suggest that programs like the academic nursing home can lead to improved process and outcomes of nursing home care."

Plant, Janet.
Nursing home chains reveal strategies. Hospitals, v. 59, June 1, 1985: M10, M12, M14.
Looks at the trend toward competition between hospitals and nursing home chains through diversification. Also discusses campaigns to attract the "private-pay clientele" using nursing home insurance.

Rango, Nicholas.
Nursing-home care in the United States: prevailing conditions and policy implications. New England journal of medicine, v. 307, Sept. 30, 1982: 883-889.

"Describes and analyzes nursing-home care in the United States with particular emphasis on economic aspects and their implications for public policy. Two questions are addressed. First of all, how do market forces and government regulations interact to affect the critical variables of supply, demand, price, access, and quality of nursing-home services? Secondly, what effect will the federal government's recent actions to reduce its contributions to Medicare have on the already difficult problems of access and quality in nursing-home care?"

Roddy, Pamela C. Liu, Korbin. Meiners, Mark R.
Resource requirements of nursing home patients based on time and motion studies; long-term care studies program research report. Rockville, Md., U.S. National Center for Health Services Research and Health Care Technology Assessment, 1987. 16 p. (U.S. Dept. of Health and Human Services. DHHS publication no. (PHS) 87-3408)

"Presents the results of the work sampling and time and motion studies conducted on the nursing home personnel used to determine the numbers, types and frequencies of services provided to nursing home Medicaid patients. These studies were conducted to determine a reasonable reimbursement scheme with appropriate incentives to encourage appropriate admission and outcome goals."

Schneider, Edward L. Ory, Marcia. Aung, Maybelle L.
Teaching nursing homes revisited: survey of affiliations between American medical schools and long-term-care facilities. JAMA [Journal of the American Medical Association], v. 257, May 22-29, 1987: 2771-2775.

"Assesses the number and types of affiliations between medical schools and chronic care facilities, examines the teaching and research involvement by faculty and staff in these programs, and investigates current sources of support."

Sekscenski, Edward S.
Discharges from nursing homes: preliminary data from the 1985 National Nursing Home Survey. NCHS [National Center for Health Statistics] advancedata, no. 142, Sept. 30, 1987: 1-16.

Sirrocco, Al.
Nursing and related care homes as reported from the 1986 inventory of long-term care places. NCHS [National Center for Health Statistics] advance data, no. 147, Jan. 22, 1988: 1-12.

Strahan, Genevieve.
Nursing home characteristics: preliminary data from the 1985 National Nursing Home Survey. NCHS [National Center for Health Statistics] advancedata, no. 131, Mar. 27, 1987: 1-12.

Thornburn, Phyllis. Meiners, Mark R.
Nursing homes patient outcomes: the results of an incentive reimbursement experiment. Rockville, Md., National Center for Health Services Research, 1986. 11 p. (U.S. Dept. of Health and Human Services. DHHS publication no. (PHS) 86-3400)

At head of title: Health Care for the Aging.

"Long-term Care Studies Program Research Report"

"Presents findings from a major demonstration and evaluation project which studied the consequences of using incentive payments to change admission, discharge and outcome patterns for Medicaid patients in nursing homes . . . . This report presents the results of the outcome-incentive component of the study."

Ullmann, Steven G.
Ownership, regulation, quality assessment, and performance in the long-term health care industry. Gerontologist, v. 27, Apr. 1987: 233-239.

Within the 1976 population of New York state nursing homes, proprietary nursing homes were found to have lower costs than not-for-profit and government homes. This difference transcends facility size and resident mix, as well as quality."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment.
Institute of Medicine study on nursing home regulation. Joint hearing before the Subcommittee on Health and the Environment and the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce and the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Mar. 25, 1986. Washington, G.P.O., 1986. 88 p.
"Serial no. 99-96 (Committee on Energy and Commerce)"
"Serial no. 99-582 (Select Committee on Aging)"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Nursing home insurance: exploiting fear for profit? (An examination of an emerging long-term care insurance market); a briefing report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, U.S. House of Representatives, 100th Congress, 1st session. Washington, G.P.O., 1987. 37 p.
At head of title: Committee print.
"Comm. pub. no. 100-634"

The rights of America's institutionalized aged: lost in confinement. Hearing, 99th Congress, 1st session. Sept. 18, 1985. Washington, G.P.O., 1986. 199 p.
"Comm. pub. no. 99-543"

U.S. Congress. Senate. Special Committee on Aging.
The Federal-state effort in long-term care for older Americans: nursing homes and "alternatives". Hearing, 95th Cong., 2d sess. Washington, U.S. Govt. Print. Off., 1979. 87 p.
Hearing held in Chicago, Ill., Aug. 30, 1978.

VanNostrand, Joan F., and others.
The national nursing home survey: 1977 summary for the United States. Hyattsville, Md., Office of Health Research, Statistics, and Technology, U.S. National Center for Health Statistics for sale by the Supt. of Docs., G.P.O., 1979. 213 p. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (PHS) 79-1794 U.S. National Center for Health Statistics. Vital and health statistics. Series 13: data from the national health survey no. 43)
"Data collected in the 1977 National Nursing Home Survey (NNHS) are presented in 43 tables according to standard sets of descriptive variables. The tables are grouped into six categories: facility, staff, financial, resident, discharge, and charge characteristics. Data are presented that measure utilization, staffing patterns, cost of providing care, health and functional status of residents and discharges, and payment for care."

Willemain, Thomas R.
Regulatory response to variations in the supply of nursing home beds. Public policy, v. 27, fall 1979: 457-467.
"Current regulatory practice seeks to reduce the supply of nursing home beds in areas that rank high in number of beds per capita. The presumption is that a high rank signals 'overbedding,' i.e., an excess of beds over need . . . . Analysis reveals that beds per capita is a poor indicator of the relative probability that an area is overbedded."

Wilson, Sally Hart.
Nursing home patients' rights: are they enforceable? Gerontologist, v. 18, June 1978: 255-261.
"The nursing home patients' bill of rights now found in federal Medicare and Medicaid regulations reflects public concern that the personal liberties of institutionalized elderly are often denied. The regulations provide for enforcement by: first, the nursing home administrator; and second, the governmental certification process."

Wingard, Deborah L. Jones, Denise Williams. Kaplan, Robert M.
Institutional care utilization by the elderly: a critical review. Gerontologist, v. 27, Apr. 1987: 156-163.
"Estimates of institutional care utilization by the elderly range from 4 to 63%, depending on which definition of institutional care is used, the sample selected, and the study design. Reviewed were prospective and

cross-sectional studies in which utilization was estimated, along with studies in which factors were identified that influence long-term utilization such as age, sex, availability of caregivers, and functional status."

HOME CARE FOR THE AGED

Aging, health, and family: long-term care. Edited by Timothy H. Brubaker. Newbury Park, Sage Publications, c1987. 288 p. (Sage focus editions; 85)

Auerbach, Marly. Taylor, Marietta. Marosy, John Paul.
Home care challenge: care of vulnerable elderly. Caring, v. 4, Apr. 1985: 38-40, 42.

Examines the Long Term Home Health Care Consultation Service designed "to research and develop cost-effective home health programs for the chronically ill and to work for changes in public policy that would favor the establishment and reimbursement of chronic home care services."

Branch, Laurence G. Stuart, Neil E.
A five-year history of targeting home care services to prevent institutionalization. Gerontologist, v. 24, Aug. 1984: 387-391.

"The Massachusetts Home Care Corporation network, which has increased dramatically in size since 1975, has the expressed goal of providing alternatives to institutional long-term care. This investigation conforms that home-based support service can be targeted to selected subgroups, that targeting can be maintained over a period as long as 5 years, and that the recipients of these home support services are indeed the individuals who exhibit risk factors of institutionalization in Massachusetts."

Brody, Elaine M.
Parent care as a normative family stress. Gerontologist, v. 25, Feb. 1985: 19-29.

"It is argued that parent care has become a normative but stressful experience for individuals and families and that its nature, scope, and consequences are not yet fully understood. Some of the complex factors that interact to determine filial behavior are explored. A hypothesis is advanced that may explain in part the persistence of the myth that adult children nowadays do not take care of their elderly parents as was the case in the good old days. Some of the ways in which social policy responds to knowledge about filial behavior are noted."

Patterns of parent-care when adult daughters work and when they do not, by Elaine M. Brody and Claire B. Schoonover. Gerontologist, v. 26, Aug. 1986: 372-381.

Finds that employed and nonworking married daughters "provided equal amounts of help with shopping/transportation, household tasks, managing money/service arrangement, and emotional support. Workers provided less personal care and cooking than nonworkers, with the difference being offset by purchased help."

Building a long-term care policy: home care data and implications; a report by the Chairman of the Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 98th Congress, 2nd session. Washington, G.P.O., 1985. 66 p.
At head of title: Committee print.
"Comm. pub. no. 98-484"

Cantor, Marjorie H.
Families: a basic source of long-term care for the elderly. Aging, no. 349, 1985: 8-13.

Analyzes the extent to which families members are responsible for the long-term care of the elderly and the future of family care.

Day, Alice T.
Who cares? Demographic trends challenge family care for the elderly. Washington, Population Reference Bureau, 1985. 16 p. (Population trends and public policy, no. 9)

"Examines the relationship between the elderly and their caregivers and the social changes that are reshaping family roles and altering the nature of aging in the United States."

Demkovich, Linda E.

In treating the problems of the elderly, there may be no place like home. National journal, v. 11, Dec. 22, 1979: 2154-2158.

"When it comes to long-term care for the elderly, the federal government has a one-track mind: it pays for nursing home care through the medicaid program but does little else. Now the government is thinking about taking steps to help the elderly cope outside of institutions.

Developing respite services for the elderly. Edited by Rhonda J. V. Montgomery and Joyce Prothero. Seattle, University of Washington Press, c1986. 135 p.

"Developed in part by the Pacific Northwest Long-Term Care Center, with funding from the Administration on Aging."

Partial contents.--The caregiver's perspective.--Respite as a continuum of services.--Introducing patients and families to respite.--Staffing respite programs.--Quality assurance and program evaluation.--Caregiver support evaluation.

Family issues in current gerontology. Sponsored by the Gerontological Society of America. Edited by Lillian E. Troll. New York, Springer, c1986. 382 p. (Current gerontology)

Family support and long term care: conference proceedings. Excelsior, Minn., Interstudy, c1984. 162 p.

Horne, Jo.

Caregiving: helping an aging loved one. Washington, American Association of Retired Persons; Glenview, Ill.: Scott, Foresman, Lifelong Learning Division, c1985. 319 p.

Hooyman, Nancy.

The impact of in-home services termination on family caregivers, by Nancy Hooyman, Judith Gonyea, and Rhonda Montgomery. Gerontologist, v. 25, Apr. 1985: 141-145.

"Examines the impact of a state policy change--the loss of in-home chore services--on families providing care for older relatives. The presence or absence of chore services was not associated with caregiving behavior, perceptions of burden, or stress among relatives of both terminated and continuing clients. A significant relationship was found, however, between the perception of burden and the performance of personal care tasks, which suggests that chore services do not coordinate with families regarding the most burdensome caregiving tasks."

Taking care: supporting older people and their families, by Nancy R. Hooyman and Wendy Lustbader. New York, Free Press, c1986. 322 p.

Implementing community-based long-term care: experience of New York's long term home health care program. Gerontologist, v. 24, Aug. 1984: 380-386.

"Describes the process of implementing the New York State Long Term Home Health Care Program (LTHHCP) during its initial 3 years of operation."

Lidoff, Lorraine.

Respite companion program model. Washington, National Council on the Aging, 1985, c1983. 51 p.

"Prepared with the support of the Charles Stewart Mott Foundation."

McNulty, Elizabeth G. Dann, Meryl S.

The dilemma of caring for your older loved one or friend. Springfield, Ill., C.C. Thomas, c1985. 235 p.

Morrison, Peter A.

Changing family structure: who cares for America's dependents? Santa Monica, Calif., Rand, 1986. 18 p.

"N-2518-NICHD"

"Reviews several ongoing demographic changes in families and considers their implications for legislation. Those changes include the growing instability of contemporary families; their increasingly diverse, often nontraditional, forms; the altered social settings and economic circumstances affecting children; and the lengthening of life expectancy among other Americans."

Moseley, Charles J.
Home health: who cares for the elderly? Washington, Congressional Quarterly, 1986. 855-871 p. (Editorial research reports, 1986, v. 2, no. 19)

Contents.--Upsurge in elderly home care.--Proliferation of for-profit health agencies.--Long-term care dilemma.--Proposals to expand or replace Medicare.--Fight expected over private-sector thrust.

Our aging parents: a practical guide to eldercare. Edited by Colette Browne and Roberta Onzuka-Anderson. Honolulu, University of Hawaii Press, c1985. 278 p. (A Kolowalu book)

Pegels, C. Carl.
Institutional vs. noninstitutional care for the elderly. Journal of health politics, policy and law, v. 5, summer 1980: 205-212.

"The question of institutionalization vs. home care of the aged in need of medical care has been debated extensively. The arguments for deinstitutionalization have stressed the issue of cost. Home care is felt to be more cost efficient than institutional care."

Roberts, Lowell.
A case against government incentives for home care of dependent adults. New England journal of human services, v. 3, fall 1983: 14-20.

Argues that "when all the research is sifted, the evidence shows simply that, whatever the level of dependency or type of need, some people are better off alone or with spouse, some with family or friends, and some in institutions. Public policy should not have the effect of pressuring families to elect one alternative over others, except to the extent that it is demonstrably best for a particular situation. Incentives for home care cannot, therefore, be defended as a component of a sound national aging, handicapped, or family policy."

Schorr, Alvin.
"Thy father & thy mother . . ." a second look at filial responsibility & family policy. Washington, U.S. Social Security Administration, for sale by the Supt. of Docs., G.P.O., 1980. 62 p. (U.S. Dept. of Health And Human Services. DHHS publication no. (SSA) 13-11953)

Social bonds in later life: aging and interdependence. Edited by Warren A. Peterson and Jill Quadagno. Beverly Hills, Sage Publications, c1985. 447 p.

"Published in cooperation with the Midwest Council for Social Research in Aging."

Social support networks and the care of the elderly: theory, research, and practice. Edited by William J. Sauer and Raymond T. Coward. New York, Springer, c1985. 284 p. (Springer series on adulthood and aging; v. 14)

Soldo, Beth J.
The elderly home care population: national prevalance rates, select characteristics and alternative sources of assistance. Washington, Urban Institute, 1983. 30 p. (Working paper 1466-29)

Seeks "to provide national prevalence estimates of the need for long term care (LTC) in the community over time and across relevant subgroups; to profile those in need of home care in order to identify correlates and risk factors; and to relate the need for home care, by type, to ways in which these needs are satisfied."

Stone, Robyn. Cafferata, Gail Lee. Sangl, Judith.
Caregivers of the frail elderly: a national profile. [Washington] U.S. National Center for Health Services Research and Health Care Technology Assessment, [1986] 23 p.

"An examination of data from the 1982 National Long-Term Care Survey reveals that informal caregivers to the disabled elderly are predominantly female and that three-quarters of them live with the care recipient. The data suggest that caregivers as well as care recipients are a vulnerable group since one-third are over age 65, report incomes in the poor to near-poor category and describe their health status as fair or poor . . . . There also is evidence of competing familial and employment demands among a subgroup of caregivers."

Caregivers of the frail elderly: a national profile. Gerontologist, v. 27, Oct. 1987: 616-626.

Supports for family caregivers of the elderly: highlights of a national symposium. Compiled by Lorraine Lidoff. Washington, National Council on the Aging, c1985. 60 p.
Held in Washington, D.C., Sept. 18-19, 1984.

U.S. Congress. House. Select Committee on Aging.
Home care for the elderly: the need for a national policy. Hearing, 95th Congress, 2nd session. Feb. 22, 1978. Washington, G.P.O., 1978. 392 p.
"Comm. pub. no. 95-139"

U.S. Congress. Senate. Committee on Labor and Human Resources.
Home health care: future policy. Joint hearing before the Committee on Labor and Human Resources and the Special Committee on Aging, 96th Congress, 2nd session. Washington, G.P.O., 1981. 332 p.
Hearing held Nov. 23, 1980, Princeton, N.J.

U.S. Congress. Senate. Committee on Labor and Human Resources. Subcommittee on Aging.
Alzheimer's disease. Hearing, 100th Congress, 1st session. Washington, G.P.O., 1987. 78 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-321)
Hearing held Aug. 19, 1987 in Cleveland Heights, Ohio.

U.S. Congress. Senate. Special Committee on Aging.
Home care: the agony of indifference; the role of the Older Americans Act in assuring access to quality home care. Hearing, 100th Congress, 1st session. Apr. 27, 1987. Washington, G.P.O., 1987. 230 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-184)
"Serial no. 100-5"

Long-term care: a look at home and community-based services. Hearing, 98th Congress, 2nd session. Washington, G.P.O., 1984. 45 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-938)
Hearing held Apr. 13, 1984, Granite City, Ill.

U.S. General Accounting Office.
Home health--the need for a national policy to better provide for the elderly; report to the Congress by the Comptroller General of the United States. [Washington] 1977. 67 p.
"HRD-78-19, Dec. 30, 1977"
"Discusses the cost of providing home health care to the elderly, including the value of services provided by family and friends, by level of impairment as compared with the cost of nursing home care and discusses the estimated cost of certain proposed legislative changes for liberalizing home health benefits under Medicare and the need for a national policy to better provide for the elderly where the services of families and friends are not available."

Working Conference on Families (Minneapolis : 1984)
Family support and long term care: conference proceedings. Excelsior, Minn., InterStudy, 1984. 162 p.
Partial contents.--Family care of elder relatives: the impact of policy and programs.--Self-help and mutual aid groups: their role in helping families of the aged.--Attitudes and perceptions of policy changes in long-term care: a four-State survey.

DAY CARE FOR THE AGED

Directory of adult day care in America 1987. Washington, National Council on the Aging, 1987. 154 p.
"This publication is a result of a national survey of adult day care centers in the United States conducted in 1985-86 by the National Council on the Aging and the National Institute on Adult Daycare (NIAD)."

Folsom, James C.
Rehabilitation psychiatry offers long-range payoffs. Hospitals, v. 54, July 16, 1980: 59-61.
Focuses on the provision of rehabilitative psychiatry and medical services to the aged through day care programs. These provide "a wide

range of psychiatric, speech and hearing, social adjustment, physical and occupational therapies, and allied services . . . . In addition, such programs focus on maintenance of function in the activities of daily living, with a key component in all such programs being social and recreational activity."

Hannan, Edward L. O'Donnell, Joseph F.
Adult day care services in New York State: a comparison with other long-term care providers. Inquiry (Chicago), v. 21, spring 1984: 75-83.
"Categorizes existing New York State nonoccupant programs into four types . . . . Compares the patient characteristics and costs of nonoccupant programs with those of the most similar long-term care providers in the state, namely, certified home health agencies and health-related facilities."

Harder, W. Paul. Gornick, Janet C. Burt, Martha R.
Adult day care: supplement or substitute? Washington, Urban Institute, 1983. 38, 3, 1 p.
Traces the growth and current status of adult day care programs and examines the research evidence on "whether adult day care has been successful in keeping impaired adults out of hospitals and nursing homes or whether it serves primarily to supplement the care of impaired people living in their communities who, despite their impairment, are unlikely to become institutionalized without such care."

Mace, Nancy L. Rabins, Peter V.
A survey of day care for the demented adult in the United States. [Washington] National Council on the Aging, 1984. 111 p.
Reports the "findings of a survey of 346 adult day care centers in the United States that serve at least some clients with dementia. The study examined characteristics of clientele, staff, services and programming, problems of client families, funding and fees, physical plant, affiliation and service hours. Centers with a small proportion of demented clients were compared with centers with a majority."

National Institute on Adult Daycare.
Standards for adult day care. Washington, National Council on the Aging, 1984. 52 p.
Based on a review of state standards, specific recommendations are made "for generic national standards that addressed the following: What is adult day care? What is the target population? What services should be provided through adult day care centers? What activities most effectively meet the needs of frail and impaired adults? What operational components are essential, such as staffing patterns, eligibility criteria, physical setting, etc.?"

U.S. Congress. House. Select Committee on Aging.
Trends in long-term care: adult day care and other options in Michigan. Hearing, 98th Congress, 2nd session. Washington, G.P.O., 1985. 45 p.
"Comm. pub. no. 98-485"
Hearings held Sept. 22, 1984 in Warren, Mich.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Adult day care programs. Hearing, 96th Cong., 2d sess. Apr. 23, 1980. Washington, U.S. Govt. Print. Off., 1980. 297 p.
"Comm. pub. no. 96-260"

Alzheimer's disease: Pennsylvania perspective. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1986. 58 p.
Hearing held in Erie, Pa., Nov. 25, 1985.
"Comm. pub. no. 99-548"

VonBehren, Ruth.
Adult day care in America: summary of a national survey. Washington, National Council on the Aging, 1986. 34 p.
Partial contents.--Where are the respondents located?--Who provides adult day care?--Are ADC centers accountable?--How long have ADC centers been operating?--How much does ADC cost?--Who pays for ADC?

Weissert, William G.
Costs of adult day care: a comparison to nursing homes. Inquiry, v. 15, Mar. 1978: 10-19.
"Examines the important dimension of costs of care in adult day care in comparison to nursing homes."

Rationales for public health insurance coverage of geriatric day care: issues, options, and impacts. Journal of health politics, policy and law, v. 3, winter 1979: 555-567.

Effects and costs of day care and homemaker services for the chronically ill: a randomized experiment, by William G. Weissert, Thomas T. Wan, and Barbara B. Livieratos. Hyattsville, Md., National Center for Health Services Research, available from NTIS [1980]. 64 p. (Research report series. U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (PHS) 79-3258)
"Study was designed to examine the effects of adult day care and homemaker services on a Medicare-eligible population and to assess the impacts of those services on institutionalization, outcomes, and Medicare costs."

HOUSING FOR THE AGED

Arnold, Gail D.
Housing of the rural elderly. Washington, U.S. Dept. of Agriculture, Economic Research Service, for sale by the Supt. of Docs., G.P.O., distributed by National Technical Information Service, Identification Section, 1984. 11 p. (Rural Development Research report no. 42)
Presents a "detailed descripton" of the demographic and housing characteristics (i.e., quality and affordability) of the rural elderly. Findings show that "most elderly people in the United States live in adequate housing, but in rural areas, 27 percent of the elderly renters and 18 percent of all the elderly living in the South have inadequate housing; . . . and that the majority of elderly heads of household in rural areas are white, married males aged 65-75 years old with less than a ninth grade education."

Assessing the elderly's preferences for lifecare retirement options. Gerontologist, v. 27, no. 4, 1987: 503-509.
"Life Care at Home (LCAH), a new long-term care option, provides benefits similar to a continuing care retirement community (CCRC) at less cost to elderly who prefer to remain in their own homes. Surveys of applicants at two CCRCs revealed that nearly half expressed interest in LCAH. Those joining CCRCs primarily for social rather than health and financial reasons were less likely to be interested in LCAH. Those more likely to be interested in LCAH were concerned about community living, lifestyle changes in a CCRC, and its costs."

Beckerman, David S.
Rental retirement homes: how will the market fare? Mortgage banking, v. 47, July 1987: 18, 20-22.
Although rental retirement housing is projected to grow rapidly during the next 50 years, "current trends in the residential mortgage industry may dampen future demand for rental retirement housing." The growth of home equity loans may impact negatively on home equity accumulation which is essential to the affordability of future rental housing.

Bernstein, Judith.
Who leaves--who stays: residency policy in housing for the elderly. Gerontologist, v. 22, June 1982: 305-313.
"As tenants in all-elderly housing projects grow older, management faces the difficult decision of determining when a resident can no longer handle independent living. The results of a 232-person survey include descriptions of tenant admission and retention policies, the range of tenant problems acceptable and unacceptable upon application and when they subsequently develop, and the role of such factors as design, on-site services, sponsorship type, and staff training in determining policy strictness. Findings show a need for better coordinated admission and retention policies and for management to work with gerontologists and service providers in establishing and implementing policies."

Blank, Thomas O.
Older persons and their homes, today and tomorrow: a research monograph on housing. [Harrisburg] Pennsylvania Dept. of Aging, [1986] 60 leaves.
Prepared under contract from the Pennsylvania Department of Aging to Lehigh University.

Boston, Helen S.
Housing and living arrangements for the elderly: a selective bibliography. Washington, National Council on the Aging, c1985. 40 p.

Branch, Laurence G.
Continuing care retirement communities: self-insuring for long-term care. Gerontologist, v. 27, Feb. 1987: 4-8.
"Impoverishment as a consequence of continuous institutionalization in a nursing home is both an important public policy problem and the plight of too many older Americans. One form of long-term care (LTC) insurance, the continuing care retirement community (CCRC) or life care community, is discussed in detail. This small long-term care self-insurance group is contrasted with two other forms of LTC insurance."

Brown, David S.
Housing for the elderly: Federal subsidy policy and its effect on age-group isolation. Journal of urban law, v. 57, winter 1980: 257-293.
Article reviews the position and function of older people in American society and focuses on the "substantial role that federal housing subsidy programs play in the phenomenon of age-group isolation."

Carlin, Vivian F. Mansberg, Ruth.
Where can mom live? A family guide to living arrangements for elderly parents. Lexington, Mass., Lexington Books, c1987. 206 p.

Continuing-care communities for the elderly: potential pitfalls and proposed regulation. University of Pennsylvania law review, v. 128, Apr. 1980: 883-936.

Continuing care retirement communities: an industry in action: analysis and developing trends, 1987. Washington, American Association of Homes for the Aging, c1987. 47 p.
Cover title: "The National Continuing Care Data Base: a joint project of the American Association of Homes for the Aging and Ernst & Whinney."

Gold, Margaret.
Guide to housing alternatives for older citizens. Mount Vernon, N.Y., Consumer Reports Books, c1985. 170 p.
"Formerly published by the Institute for Consumer Policy Research as The older American's guide to housing and living arrangements."

Green, Roberta R.
Social work with the aged and their families. New York, Aldine de Gruyter, c1986. 261 p.

Hancock, Judith Ann. Duensing, Edward E.
Housing the elderly: options and policies. Monticello, Ill., Vance Bibliographies, 1986. 35 p. (Public administration series: bibliography P-1913)

Hare, Patrick H. Haske, Margaret.
Innovative living arrangements: a source of long-term care. Aging, no. 342, Dec. 1983-Jan. 1984: 3-8.
Concludes that "innovative living arrangements should be encouraged as a way of reducing the institutional provision of long-term care and increasing the quality of life, but not, under existing legislation, as a way of reducing the demand for public subsidies for long-term care."

Hoeflich, M. H.
Housing the elderly in a changing America: innovation through private sector initiative. University of Illinois law review, v. 1985, no. 1, 1985: 1-38.
Article "outlines the current and past thrust of governmental activities, at both the federal and state levels, designed to provide housing aid to the elderly, and shows that much of this governmental effort has ignored elderly homeowners. Because of this governmental oversight, this article considers the increasingly large group of elderly homeowners who wish to retain some equity interest either in their present housing or in new

housing, and sketches innovative ways in which the private sector, without direct government subsidy or intervention, can provide economically rational solutions to the problems of elderly homeownership."

Housing an aging society: issues, alternatives, and policy. Edited by Robert J. Newcomer, M. Powell Lawton, and Thomas O. Byerts. New York, Van Nostrand Reinhold, c1986. 246 p.

Housing for older adults: options and answers. Edited by Robert L. Cosby, Jr. and Teri Flynn. Prepared by the National Council on the Aging. Washington, The Council, c1986. 97 p.

Housing the elderly. Edited by Judith Ann Hancock. New Brunswick, N.J., Center for Urban Policy Research, c1986. 324 p.

Jacobs, Bruce. Weissert, William G.
Helping protect the elderly and the public against the catastrophic costs of long-term care. Journal of policy analysis and management, v. 5, winter 1986: 378-383.
Points out that "the number of older people who require long-term care will increase steadily in the decades to come. Reverse mortgages could substantially improve the monthly budgets of those most likely to need extended care, who are also least likely to have other income and liquid assets to pay for it."

Jirovec, Ronald L. Jirovec, Mary Marmoll. Bosse, Raymond.
Environmental determinants of neighborhood satisfaction among urban elderly men. Gerontologist, v. 24, June 1984: 261-265.
Examines "a broad range of environmental characteristics in hopes of identifying environmental determinants of neighborhood satisfaction among urban elderly men. Safety on neighborhood satisfaction was lessened when considered in conjunction with housing satisfaction."

Lane, Terry Saunders. Feins, Judith D.
Are the elderly overhoused? Definitions of space utilization and policy implications. Gerontologist, v. 25, June 1985: 243-250.
"Explores the widely-held belief that elderly-headed households live in dwellings too large for their needs and more suitable for larger families. Using data from recent Annual Housing Surveys, the article demonstrates that most elderly households do not underutilize their housing space. In addition, few of their units become available for reoccupancy each year, because mobility rates among the elderly, especially those in underutilized dwellings, are very low. When the elderly do release their homes into the market, the new occupants include a wide range of household types, not just younger, larger families."

Lawton, M. Powell.
Environment and aging. Albany, N.Y., Center for the Study of Aging, c1986. 205 p. (Classics in aging reprinted. Series I; v. 1)

Lee, Gary R. Lassey, Marie L.
Rural-urban differences among the elderly: economic, social, and subjective factors. Journal of social issues, v. 36, no. 2, 1980: 62-74.
"Reviews previous research on differences between elderly persons residing in urban and rural locations. While the urban elderly have demonstrable advantages in terms of many 'objective' indicators of quality of life, they appear to have no corresponding advantage in terms of subjective or emotional well-being, and perhaps even show a small disadvantage on such dimensions."

Leigh, Wilhelminia A.
Federal housing programs and the Black elderly. Urban League review, v. 5, summer 1981: 35-50.
"The federal government has established many assisted housing programs to help the housing needy. However, out of all such programs for which the elderly are eligible, either by virtue of their elderly status or by virtue of their low incomes, the black elderly are found to be concentrated in low-income rental housing."

Mayer, Neil S.
Grants, loans, and housing repair for the elderly. Journal of the American Planning Association, v. 47, Jan. 1981: 25-34.
"Using detailed data on past program recipients, this article demonstrates that providing assistance in the form of grants rather than

loans is critical to gaining elderly households' participation. It also shows that inability to qualify for or repay loans because of low incomes, more than unwillingness to borrow, limits participation by the elderly in repair loan programs. The paper considers various options for obtaining improved housing quality for elderly people and concludes that providing and expanding grant assistance for home repair and rehabilitation is a necessary major component of successful policy."

Federal home repair programs and elderly homeowners' needs, by Neil S. Mayer and Olson Lee. Gerontologist, v. 21, June 1981: 312-322.
"Overall, the elderly receive less than the proportion of all federal aid for these purposes that their share of homeowners' need would imply. But home repair programs differ widely in their service to older owners. Programs can be designed to target more aid to the elderly."

Nathanson, Iric.
Housing needs of the rural elderly and the handicapped. [Washington] U.S. Dept. of Housing and Urban Development, Office of Policy Development and Research [1980] 36 p. (U.S. Dept. of Housing and Urban Development. HUD-PDR-633)

Netting, F. Ellen. Wilson, Cindy C.
Current legislation concerning life care and continuing care contracts. Gerontologist, v. 27, Oct. 1987: 645-651.
"A 1986 national survey revealed 20 states with legislation and 7 states with bills" pertaining to life care and continuing care retirement communities.

New challenges in national housing policy for older Americans. Gerontologist, v. 25, Feb. 1985: 30-46.
Contents.--Introduction.--The relevance of impairments to age targeting of housing assistance, by M. Lawton.--Housing and long-term care: the suitability of the elderly's housing to the provision of in-home services, by S. Newman.--Future housing assistance for the elderly, by R. Struyck.

Newman, Sandra J. Reschovsky, James D.
Federal policy and the mobility of older homeowners. Journal of policy analysis and management, v. 6, spring 1987: 402-416.
"Evaluates the extent to which the one-time capital gains exclusion provisions succeeds in generating greater mobility among older homeowners."

Pollak, Patricia Baron.
Aging-in-place: five housing alternatives for the elderly. Monticello, Ill., Vance Bibliographies, 1985. 9 p. (Architecture series: bibliography A 1490)
Bibliographic references include books and articles on "match-up home sharing, shared living residences (or, group homes), accessory apartments, ECHO housing (or, granny flats), and home equity conversion."

Poulin, John E.
Age segregation and the interpersonal involvement and morale of the aged. Gerontologist, v. 24, June 1984: 266-269.
"Examines the relationship between residential age segregation and the interpersonal involvement and morale of the elderly. Focuses on the effect of age segregation upon the elderly's interpersonal involvement with close friends and relatives and their overall life satisfaction."

Pynoos, Jon.
Setting the elderly housing agenda. Policy studies journal, v. 13, Sept. 1984: 173-184.
"Discusses the importance of housing for the elderly, describes the major actors in the policy arena, analyzes the influence that elderly interest groups have had on policy, identifies agenda items that have yet to be addressed, highlights emerging directions in housing policy and suggests how current developments may influence the future agenda of elderly housing."

Rasmussen, John A.
Retirement community development: new trends in marketing and financing concepts. Real estate issues, v. 11, fall-winter 1986: 19-26.
Describes consumer marketing and financing plan alternatives for retirement communities, especially life care communities, and adult

independent living. Historical absorption, recent trends and current primary market research findings are analyzed to perceive the potential demand in the market.

Reschovsky, James.
Housing and long-term care for the elderly. Human ecology forum, v. 16, winter 1987: 13-16.
Urges society to "strive to expand the availability and range of housing options, such as accessory apartments where services are provided by family and friends, or various types of congregate housing where services can be provided in a cost-efficient manner. These intermediate settings can minimize the placement of the elderly in settings too intensive and too expensive for their condition while respecting their desire for independent living."

Samuelson, Don S.
Accommodating the graying of America: a competitive viewpoint. Urban land, v. 40, Jan. 1981: 4-10.
Advocates the development of housing strategies for the elderly "within the context of the economic system consisting of the various federal, state, local, and private programs for the elderly; the numerous public and private intermediaries linking income assistance, insurance, medical, and service programs with the elderly, and with the rest of the economy; and the diverse groups that are indiscriminately lumped together as 'elderly.'"

Schwartz, David C.
Housing America's elderly: a state-level policy perspective. Policy studies journal, v. 13, Sept. 1984: 157-171.
Examines what has been done in New Jersey to create diverse types of housing alternatives for the aged.

Sheehan, Nancy W.
Aging of tenants: termination policy in public senior housing. Gerontologist, v. 26, Oct. 1986: 505-509.
"Termination policies and procedures in public senior housing in Connecticut were assessed. The majority of housing authorities had no formal termination policy and no established procedures for managing a frail population. A lack of congruence between termination policies, monitoring practices, and on-site services also was found. The paper discusses the need for policy to address the 'aging of tenants.'"

Steinhauer, Marcia B.
Housing trends of the elderly: emerging policy and implications. International journal of public administration, v. 3, 1981: 283-312.
"Analyzes the topic of housing and the elderly so as to highlight selected dimensions that might have implications for decision-makers in resource considerations and allocations."

U.S. Congress. House. Committee on Banking, Finance and Urban Affairs. Subcommittee on Housing and Community Development.
Section 8 rent adjustments, elderly housing, and other assisted housing issues. Hearing, 98th Congress, 2nd session. Feb. 22, 1984. Washington, G.P.O., 1984. 162 p.
"Serial no. 98-71"

Housing Act of 1985--parts 1-3. Hearings, 99th Congress, 1st session on H.R. 1, a bill to amend and extend certain laws relating to housing, and for other purposes. Washington, G.P.O., 1985. 3 v. (2486 p.)
Hearings held on Feb. 21-Mar. 12, 1985.
"Serial no. 99-9"

U.S. Congress. House. Select Committee on Aging.
Elderly housing options: a blueprint for the future. Joint hearing before the Select Committee on Aging and the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Feb. 25, 1986. Washington, G.P.O., 1986. 50 p.
"Comm. pub. no. 99-559"

Fraud and abuse in boarding homes. Hearing, 97th Congress, 1st session. June 25, 1981. Washington, G.P.O., 1981. 116 p.
"Comm. pub. no. 97-295"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care.
Housing the elderly: integration of health and social services. Joint Subcommittee on Housing and Consumer Interests of the House Select Committee on Aging, 95th Congress, 1st session. Mar. 24, 1977. Washington, G.P.O., 1977. 214 p.
"Comm. pub. no. 95-99"

Long-term care for the 1980's: channeling demonstrations and other initiatives. Hearing, 96th Cong., 2d sess. Feb. 27, 1980. Washington, U.S. Govt. Print. Off., 1980. 47 p.
"Comm. pub. no. 96-234"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Housing and Consumer Interests.
Alternative housing options for the elderly. Hearing, 96th Congress, 2nd session. Washington, G.P.O., 1981. 49 p.
Hearing held Oct. 6, 1980, Denver, Colo.
"Comm. Pub. no. 96-270"

Condominium conversions. Hearing, 96th Congress, 2nd session. May 15, 1980. Washington, G.P.O., 1980. 429 p.
"Comm. pub. no. 96-246"

Congregate housing services: benefits of supportive environments in assisted housing for the rural elderly. Hearing, 99th Congress, 2nd session. Washington, G.P.O., 1986. 53 p.
Hearing held on January 21, 1986, at Jamestown, N.Y.
"Comm. pub. no. 99-554"

Elderly housing: innovative alternatives. Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 50 p.
"Comm. pub. no. 98-434"
Hearing held Aug. 12, 1983, Portland, Or.

Housing the elderly: alternative options (Erie, Pa.). Hearing, 98th Congress, 1st session. Washington, G.P.O., 1984. 51 p.
Hearing held in Erie, Pa., Oct. 17, 1983.
"Comm. pub. no. 98-421"

Housing the elderly: present problems and future considerations. Hearing, 97th Congress, 1st session. July 29, 1981. Washington, G.P.O., 1982. 116 p.
"Comm. pub. no. 97-318"

The impact of the administration's fiscal year 1986 budget proposals on housing for the elderly. Hearing, 99th Congress, 1st session. Mar. 7, 1985. Washington, G.P.O., 1986. 180 p.
"Comm. pub. no. 99-546"

Maximizing supportive services for the elderly in assisted housing: experiences from the congregate housing services program. Hearing, 99th Congress, 1st session. Oct. 2, 1985. Washington, G.P.O., 1986. 87 p.
"Comm. pub. no. 99-553"

The Reagan budget cuts: effects on housing and security needs of the elderly in Detroit, Mich. Hearing, 97th Congress, 2nd session. Washington, G.P.O., 1982. 146 p.
"Comm. pub. no. 97-348"
Hearing held on Mar. 5, 1982, Detroit, Mich.

Section 202: GAO evaluation on HUD's selections process. Hearing, 98th Congress, 2nd session. Oct. 31, 1984. Washington, G.P.O., 1985. 69 p.
"Comm. pub. no. 98-498"

Section 202: present problems--proposed alternatives. Hearing, 98th Congress, 2nd session. Apr. 11, 1984. Washington, G.P.O., 1985. 77 p.
"Comm. pub. no. 98-483"

Senior citizen housing: an emerging crisis in America. Hearing, 99th Congress, 1st session. Washington, G.P.O., 1986. 91 p.
"Comm. pub. no. 99-526"
Hearing held June 17, 1985, Hamilton Township, NJ.

White House Conference on Aging housing recommendations. Hearing, 97th Congress, 2nd session. Mar. 8, 1982. Washington, G.P.O., 1982. 147 p.
"Comm. pub. no. 97-343."

U.S. Congress. Senate. Committee on Appropriations.
Congregate housing services program. Hearing, 95th Congress, 2nd session. Washington, For sale by the Supt. of Docs., G.P.O., 1978.
101 p.
Special hearing--Dept. of Housing and Urban Development, and Departments of Labor, and Health, Education, and Welfare.

U.S. Congress. Senate. Committee on Banking, Housing and Urban Affairs.
Subcommittee on Housing and Urban Affairs.
Congregate Housing Services Act of 1978. Hearing, 95th Congress, 2nd session. on S. 2691. Apr. 13, 1978. Washington, G.P.O., 1978. 234 p.

U.S. Congress. Senate. Special Committee on Aging.
Alternative approaches to housing older Americans. Hearing, 97th Congress, 2nd session. Washington, G.P.O., 1982. 94 p.
Hearing held in Hartford Feb. 1, 1982.

The impact of the Administration's housing proposals on older Americans. Hearing, 97th Congress, 2nd session. Apr. 23, 1982. Washington, G.P.O., 1983. 70 p.

Life care communities: promises and problems. Hearing, 98th Congress, 1st session. May 25, 1983. Washington, G.P.O., 1983. 171 p. (Hearing, Senate, 98th Congress, 1st session, S. Hrg. 98-276)

Low-cost housing for the elderly: surplus lands and private-sector initiatives. Hearing, 98th Congress, 2nd session. Washington, G.P.O., 1984. 68 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-1157)
Hearing held in Sacramento, Calif., Aug. 13, 1984.

Section 202 housing for the elderly and handicapped: a national survey; an information paper prepared by the staff of the Special Committee on Aging, United States Senate. Washington, G.P.O., 1984. 62 p. (Print, Senate, 98th Congress, 2nd session, committee print S. Prt. 98-257)

Sheltering America's aged: options for housing and services. Hearing, 98th Congress, 2nd session. Washington, G.P.O., 1984. 114 p. (Hearing, Senate, 98th Congress, 2nd session, S. Hrg. 98-875)
Hearing held in Boston, Mass., Apr. 23, 1984.

U.S. Dept. of Housing and Urban Development. Division of Policy Studies.
Housing for the elderly and handicapped: the experience of the Section 202 program from 1959 to 1977. Washington, [1979] 143 p.
"The major finding of this evaluation is that Section 202 has generally produced good quality, cost-effective and financially viable housing projects for elderly persons."

U.S. Dept. of Housing and Urban Development. Office of Policy Development and Research. Division of Policy Studies.
The conversion of rental housing to condominiums and cooperatives: impacts on elderly and lower income households. [Washington] 1981 [i.e., 1982] 54 p.
"HUD-PDR-689"
This report is a technical supplement to The Conversion of Rental Housing to Condominiums and Cooperatives: A National Study of Scope, Causes and Impacts, published by the Department in June 1980. It deals with the impacts of the conversion phenomenon on elderly and low income households who lived in rental buildings prior to their conversion.

U.S. General Accounting Office.
Elderly housing: successes/problems in implementing HUD's cost containment requirements; briefing report to the Chairman, Special Committee on Aging, U.S. Senate. Dec. 1985. Washington, G.A.O., 1985. 16 p.
"GAO/RCED-86-55 BR"

Welfeld, Irving. Struyk, Raymond J.
Housing options for the elderly. [Washington] U.S. Dept. of Housing and Urban Development, Office of Policy Development and Research [1978] 104 p. (U.S. Dept. of Housing and Urban Development. Occasional papers in housing and community affairs, vol. 3)
"This policy review attempts to consider the housing needs of the elderly in a manner that builds on the obvious diversity of their housing needs."

Zais, James P. Thibodeau, Thomas G.
The elderly and urban housing. Washington, Urban Institute Press, 1983. 107 p.

WHAT SHOULD THE FEDERAL GOVERNMENT DO TO ENHANCE THE QUALITY OF LIFE FOR UNITED STATES CITIZENS OVER AGE 65?

A Guide to Information Sources on the 1988-1989 High School Debate Topic

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A GUIDE TO INFORMATION SOURCES
on the 1988-1989
High School Debate Topic

INTRODUCTION

This research guide identifies sources of information on Federal aging policies and related topics that will be discussed by high school debaters. It describes reference and research tools and suggests particular search strategies that might be used.

In some cases, search terms are provided for each resolution of the debate topic. These search terms are not exhaustive. The primary terms are included to help the debaters begin their search for supporting materials on the range of issues relating to Federal concerns for the aged. As debaters concentrate on one resolution and the general issue of quality of life for the aged, they will need to scan selected relevant search terms listed under the other resolutions. In this guide, the resolutions are referred to in the abbreviated form listed in parentheses.

AGING:	What should the Federal Government do to enhance the quality of life for United States citizens over age 65? **(Aging, General)**
RESOLVED:	That the Federal Government should implement a comprehensive program to guarantee retirement security for United States citizens over age 65. **(Retirement security)**
RESOLVED:	That the Federal Government should guarantee adequate custodial care for United States citizens over age 65. **(Custodial care)**
RESOLVED:	That the Federal Government should guarantee long-term health care for United States citizens over age 65. **(Long-term health care)**

Although emphasis is given herein to printed sources, the debater will wish to note Federal, State and local agencies and non-governmental organizations which may be able to furnish information support or to present a range of policy options. Refer to the section on further contacts for suggestions.

RESEARCH SOURCES

This is a list of key research tools described in this guide, and the page where each is mentioned.

American Statistics Index 11
Bell and Howell Newspaper Indexes 7
Books in Print 1
Business Periodicals Index 5
Census Publications 9
CIS Index 11
Congressional Index 11
Congressional Quarterly Weekly Report 10
Congressional Record 10
Current Law Index 6
Depository Libraries 8
Digest of Public Bills and Resolutions 10
Directory of State and Area Agencies on Aging 13
Encyclopedia articles 2
Encyclopedia of Associations 13
Federal Register 9
Government Reports Announcements and Index 8
Hospital Literature Index 5
Index Medicus 5
Index to Legal Periodicals 6
Index to U.S. Government Periodicals 6
Library of Congress Subject Headings 1
Magazine Index 3
Major Legislation of the Congress 10
Monthly Catalog of United States Government Publications 8
National Data Base on Aging 12
National Journal 10
National Newspaper Index 7
New York Times Index 6
NEXIS 8
Official Washington Post Index 7
Psychological Abstracts 5
Public Affairs Information Service 3
Reader's Guide to Periodical Literature 4
Sears List of Subject Headings 1
Social Issues Resource Series 5
Social Science Citation Index 5
Social Sciences Index 4
Social Security Bulletin 9
Sociological Abstracts 5
Statistical Abstract of the U.S. 9
Statistical Reference Index 11
The United States Government Manual 14
University Microfilms Newspaper Indexes 7
Wall Street Journal Index 7
Washington Information Directory 14
Weekly Compilation of Presidential Documents 9
VUTEXT 8

I. BOOKS

Many libraries around the country, especially large college and research libraries, use Library of Congress subject headings in their catalogs. To learn how books on U.S. Federal aging policies are categorized in these libraries, consult the two volume guide, *Library of Congress Subject Headings*. It is usually kept near the automated catalog or card catalog. The most relevant LC subject headings for research on the aged are listed below:

AGING, GENERAL:	Aged (subdivided by topic, such as --Health and hygiene, and by location)
	Aging
	Minority aged (Many have own subject terms)
RETIREMENT SECURITY:	Aged--Economic conditions
	Aged--Taxation
	Old age pensions
	Pension funds
	Pensions (both as a term, and as a subdivision for groups of people).
	Retirement
	Social security
CUSTODIAL CARE:	Aged--Home care
	Aged--Services for
	Continuum of care (This illustrates the problem of newer terms; some libraries will convert old entries; many provide cross references, and you will find books in the library's catalog under both the newer and older headings.)
	Day care centers for the aged
	Legal assistance to the aged
	Old age homes
	Retirement communities
	Social work with the aged
LONG-TERM HEALTH CARE:	Aged--Long-term care (Also subdivisions of Institutional care, Medical care, Respite care, etc.)
	Community health services for the aged
	Continuum of care
	Health services for the aged
	Home care services (Includes home nursing)
	Life care communities
	Long-term care facilities
	Long-term care of the sick
	Medicaid
	Medicare
	Nursing homes

In many school and public libraries, books are arranged by the Dewey Decimal classification number. These are usually assigned indexing terms from the *Sears List of Subject Headings*, also generally found near the catalog.

If you cannot find books listed here or in other bibliographical sources which you are using, ask your librarian about *Books in Print* and about interlibrary loan. *Books in Print* will be useful in identifying the addresses of publishers for purchase of materials and to identify additional and recently issued books. Look particularly under the terms: Aged, Aging, Home care services, Long-term care of the sick, Nursing homes, Old age, Pensions, Retirement income, Social work with the aged, and Social security.

II. REFERENCE BOOKS

ENCYCLOPEDIA ARTICLES

Articles appear under "Old Age" in World Book Encyclopedia, in its research guide volume, in Americana Encyclopedia, and in Encyclopedia Britannica's Micropaedia. The Encyclopedia Britannica's Macropaedia uses "Social Differentiation" for its general article on problems faced by the elderly.

SELECTED REFERENCE BOOKS

See bibliography entries for additional directories, handbooks, bibliographies, and factbooks.

Crichton, Jean.
The age care sourcebook: a resource guide for the aging and their families. New York, Simon & Schuster, c1987. 335 p.

The Encyclodpedia of aging. Edited by George L. Maddox, and others. New York, Springer Pub. Co, c1987. 890 p.

Encyclopedia of public affairs information sources: a bibliographic guide to approximately 8,000 citations for publications, organizations, and other sources of information on nearly 300 subjects relating to public affairs. Edited by Paul Wasserman, James R. Kelly, and Desider L. Vikor. 1st ed. Detroit, Gale Research Co, c1988. 303 p.

Federal programs benefiting the elderly (Federal responsibility to the elderly): a reference guide, by the Select Committee on Aging, House of Representatives, 98th Congress, 1st session. Washington, G.P.O., 1983. 61 p.
"Committee print."

Handbook of gerontological services. Edited by Abraham Monk. New York, Van Nostrand Reinhold, c1985. 638 p.

A Handbook of practical care for the frail elderly. By Merlin A. Taber, and others. Phoenix, AZ, Oryx Press, 1986. 104 p.

Handbook of the biology of aging. Edited by Caleb E. Finch, and others. 2nd ed. New York, Van Nostrand Reinhold, c1985. 1025 p. (The Handbooks of aging)

Handbook on the aged in the United States. Edited by Erdman B. Palmore. Westport, Conn., Greenwood Press, 1984. 458 p.

Harris, Diana K.
The sociology of aging: an annotated bibliography and sourcebook. New York, Garland Pub, 1985. 283 p. (Garland bibliographies in sociology, vol. 5; Garland reference library of social science, vol. 206)

Killeffer, Eloise H. P. Bennett, Ruth. Gruen, Gerta.
Handbook of innovative programs for the impaired elderly. New York, Haworth Press, c1985. 126 p.

Lederman, Ellen F.
Community resources for geriatric programs: a practical guide. Springfield, Ill., C. C. Thomas, c1985. 161 p.

Monroe, Margaret Ellen. Rubin, Rhea Joyce.
The challenge of aging: a bibliography. Littleton, Colo., Libraries Unlimited, 1983. 209 p.

National continuing care directory; comprehensive information on retirement facilities and communities offering prepaid contracts for long-term care (also called life care). Edited by Ann Trueblood Raper for the American Association of Homes for the Aging. Glenview, Ill., Scott, Foresman, Lifelong Learning Division, c1984. 618 p.
An update is forthcoming in 1988.

A National inventory of services to help families care for older family members. Excelsior, Minn. (P.O. Box 458, Excelsior 55331-0458), InterStudy, c1984. 370 p.

Portnow, Jay. Houtman, Martha.
Home care for the elderly: a complete guide. New York, McGraw-Hill, c1987. 263 p.

Rabin, David. Stockton, Patricia.
Long-term care for the elderly: a factbook. New York, Oxford University Press, 1987. 248 p.
Funded by a grant from the Robert Wood Johnson Foundation.

Reed, Robert D.
How and where to research and find information about aging in America. Saratoga, Calif., R & E Publishers, c1983. 42 p.

Self-care and self-help groups for the elderly: a directory. Prepared by National Institute on Aging. Bethesda, Md., U.S. National Institutes of Health, For sale by the Supt. of Docs., G.P.O., 1984. 128 p. (NIH publication; no. 84-738)

The Social science encyclopedia. Edited by Adam Kuper and Jessica Kuper. London, Boston, Routledge & Kegan Paul, 1985. 916 p.

Stokell, Marjorie. Kennedy, Bonnie.
The senior citizen handbook: a self-help and resource guide. Englewood Cliffs, N.J., Prentice-Hall, c1985. 260 p.

Weiss, David M. Mahlmann, Diane E.
National guide to funding in aging. Long Island University, Nassau County Department of Senior Citizen Affairs, the Foundation Center. New York, The Center, 1987. 280 p.

III. JOURNAL ARTICLES

Citations to journal articles and other materials about Federal aging policies can be found in a number of printed indexes and online bibliographic data bases. The materials covered by selected printed indexes are briefly described here and search terms recommended. Printed indexes include lists of periodicals indexed and the abbreviations referring to these publications. Introductory sections are helpful in effectively using these tools.

Online bibliographic data bases are useful to locate citations to journal articles and other materials quickly by using a computer terminal to search a machine-readable file. Online data bases allow the researcher to combine search terms in ways that are impossible in a printed index or library catalog and to simultaneously search material that would be contained in printed index volumes covering several years. They also offer more timely updating than most printed tools. Many of the printed indexes described in this guide are also available as online data bases. A reference librarian can advise you on the availability of computerized search services in your area; there may be a fee for use.

MAGAZINE INDEX (microfilm)

Magazine Index provides citations to materials in over 400 popular magazines, focusing on coverage of current affairs, leisure time activities, arts, sports, and science and technology. References from the last five years are listed alphabetically by subject and author in one alphabetical display on the Magazine Index microfilm reader-terminal. The Index is updated monthly, and uses Library of Congress subject headings. Consult the list given above or the two-volume Library of Congress Subject Headings for appropriate search terms.

PUBLIC AFFAIRS INFORMATION SERVICE (PAIS)

PAIS is a subject index of books, pamphlets, government publications, reports of public and private agencies, and periodical articles relating to political, economic and social conditions, public administration and international affairs. It is issued monthly; there are also three quarterly cumulations and an annual bound volume with an author index. Some search terms are listed below; also use PAIS cross-references.

AGING: Old age (also topical and State and national subdivisions)

RETIREMENT SECURITY: Home equity conversion
Insurance, social
Old age--Economic conditions
Pensions, Old age
Retirement income
Social and economic security

CUSTODIAL CARE: Old age--Home care (and other subdivisions such as Social aspects, etc.)
Social service--Work with the aged

LONG-TERM HEALTH CARE: Insurance, Health
Medicaid program
Medicare
Nursing homes
Old age--Medical care

READER'S GUIDE TO PERIODICAL LITERATURE

The Reader's Guide is an author/subject index to over 180 periodicals of general interest published in the United States and Canada. It is published twice a month September to December and in March, April, and June; it appears monthly in January, February, May, July, and August. The quarterly and annual cumulations can expedite your search. Search under Library of Congress subject headings. Selected terms used in the Reader's Guide are listed here.

AGING: Aged (Including subdivisions such as statistics)
Aging
Gerontology

RETIREMENT SECURITY: Aged--Economic conditions
Aged--Employment
Pensions
Retirement income
Social security

CUSTODIAL CARE: Aged--Care and hygiene
Aged--Housing
Day care centers for the aged
Home care services

LONG-TERM HEALTH CARE: Aged--Medical care
Insurance, Health
Insurance, Nursing home care
Medicaid
Medicare
Nursing homes

SOCIAL SCIENCES INDEX

Social Sciences Index is a quarterly author and subject index of periodicals including coverage of the fields of community health and medical care, economics, public administration, policy sciences, social work and public welfare, sociology, and related subjects. It also lists book reviews. The index is cumulated annually.

AGING: Aged
Attitudes toward the aged

RETIREMENT SECURITY: Old age assistance
Old age pensions
Retirement income
Social security--United States

CUSTODIAL CARE:	Aged--Family relationships (other subdivisions such as Housing, and Home care)
	Aged, Abuse of the
	Community services for the aged
	Older Americans Act of 1965
	Social work with the aged
LONG-TERM HEALTH CARE:	Aged--Medical care
	Home care services (for home nursing)
	Insurance, Long-term care
	Medicaid
	Medicare
	Nursing homes

SOCIOLOGICAL ABSTRACTS

Sociological Abstracts covers journal articles, other serial publications, and conference reports in sociology and related disciplines, including family and social welfare, demography, and public policy. Use "Elderly" for articles indexed since 1985, and "Aged" for those indexed from 1963-1985. See also "Pensions" and "Social security." The most useful references may be found in the section of "Social problems and social welfare--social gerontology."

SOCIAL ISSUES RESOURCES SERIES

SIRS, published in Boca Raton, Florida, was originally designed to be used in classrooms. This looseleaf series, supplemented annually, reprints selected articles from newspapers, magazines, government publications, and monographs offering different points of view on social issues. The volumes titled "Aging" constitute a valuable collection of relevant articles of general issues discussed over the years.

SOCIAL SCIENCE CITATION INDEX

Social Science Citation Index, which covers hundreds of journals, is issued quarterly and annually. It differs from other indexes in that there are no standard subject headings; but you may search by topic by looking up key words from an article's title in its Permuterm Subject Index and referring to the Source Index for the full reference.

BUSINESS PERIODICALS INDEX

Business Periodicals index is a subject index of over 300 business periodicals. It is published monthly except August, with a bound cumulation each year. It covers a wide range of business publications, such as *American Demographics*, *Economist*, and *Barrons*. Search using Library of Congress subject headings and the index's cross-references.

PSYCHOLOGICAL ABSTRACTS

This monthly compilation of abstracts in the areas of general psychology, social processes and social issues, treatment and prevention, and related topics, is cumulated annually and also every three years. Search under "Aged."

INDEX MEDICUS
HOSPITAL LITERATURE INDEX

Both of these are included along with Medline in various commercial online systems, as well as in the printed versions. Refer to the National Library of Medicine's thesaurus of MeSH (medical subject headings) to search these indexes. These can be more complicated to use, and a reference librarian may be consulted to help you define the exact search strategy if you decide to pursue a topic, particularly in the area of health care financing.

INDEX TO LEGAL PERIODICALS

The index lists articles "of high quality and permanent reference value" in legal periodicals published in the United States, Canada, Great Britain, and other English language countries. The articles are indexed under author and subject, statutes, and cases. A complete list of subjects is included at the front of each bound volume.

AGING:	Aged
RETIREMENT SECURITY:	Pensions plans Social security
CUSTODIAL CARE:	Aged
LONG-TERM HEALTH CARE:	Medicaid Medicare Nursing homes

CURRENT LAW INDEX

The American Association of Law Libraries sponsors this index of articles in legal periodicals. Separate subject and author indexes and tables of cases and of statutes are included in eight monthly issues, three quarterly cumulations, and a cumulative annual. Library of Congress subject headings are the search terms used primarily. Of these, "Aged," "Medicaid," "Medical care, Cost of," "Medicare," "Nursing homes," "Retirement income," and "Social security" seem most useful.

IV. SELECTED PERIODICALS

Periodicals cited frequently in the bibliography, or with titles focused particularly on the aged and aging, such as Caring, published by the National Association for Home Care, or the Journal of Gerontological Social Work, may be useful to examine for the most recent articles on the aged even before they appear in the indexes. Popular journals targeted at an aging audience can add a focus on preferences of the elderly themselves. These include Modern Maturity, published by the American Association of Retired Persons (AARP), Mature Outlook, and 50 Plus.

Newsletters and publications or accessions lists from private organizations such as the National Council on Aging, 600 Maryland Ave., S.W., West Wing 200, Washington, D.C. 20024; or the AARP or its National Gerontology Resource Center, 1909 K St., Washington, D.C. 20049, may be available for purchase or subscription. Some newsletters may be available free, yet most involve a fee, like the Older Americans Report, a newsletter published weekly by BPI, 951 Pershing Dr., Silver Spring, MD. 20910, which tracks Federal legislation, describes new reports, projects, and funding opportunities.

Weekly news sources include Time, Newsweek, Senior Scholastic, and US News & World Report; monthly/quarterly general sources include Harpers, Atlantic Monthly, Reader's Digest, and law journals.

V. NEWSPAPER ARTICLES

The New York Times Index provides extensive abstracts for articles appearing in the New York Times. It is issued twice a month, with quarterly and annual cumulations. Consult "How to use the New York Times Index" in the index volume itself for guidance. Examples of some search terms are provided.

AGING:	Aged Welfare (used for both social services and income security)
RETIREMENT SECURITY:	Older workers Pensions Social security

CUSTODIAL CARE: Aged
Alzheimer's disease
Housing
Retirement
Retirement communities

LONG-TERM HEALTH CARE: Medicaid
Medicare
Medicine and health (for home health care)
Nursing homes

OFFICIAL WASHINGTON POST INDEX

The Index provides access to all substantial newsworthy items in this paper. It is issued monthly and cumulated annually. This index is more specific than many; check cross references.

AGING: Aged
Retirement

RETIREMENT SECURITY: Pensions
Retirement income
Social security

CUSTODIAL CARE: Home care services
Social service

LONG-TERM HEALTH CARE: Aged--medical care
Medicaid
Medical care, Cost of
Medicare
Nursing homes

WALL STREET JOURNAL INDEX

The Wall Street Journal Index is issued monthly and has annual cumulations. Check under the General News section, which indexes very generally.

AGING: Elderly

RETIREMENT SECURITY: Pensions
Retirement
Social security

CUSTODIAL CARE: Elderly
Retirement

LONG-TERM HEALTH CARE: Health insurance
Medicaid
Medicare
Nursing homes

NATIONAL NEWSPAPER INDEX

National Newpaper Index indexes the Christian Science Monitor, New York Times, Wall Street Journal, Los Angeles Times, and Washington Post. References from the last five years are listed alphabetically by subject headings. An online version of this index is available commercially.

OTHER NEWSPAPER INDEXES

Bell & Howell Co. produces a set of indexes which list articles appearing in the Boston Globe, Christian Science Monitor, Denver Post, Detroit News, Houston Post, Los Angeles Times, New Orleans Times-Picayune, San Francisco Chronicle, St. Louis Post-Dispatch, and USA Today. University Microfilms International produces monthly and annual indexes for the Atlanta Journal, Atlanta Constitution, Chicago Tribune, Los Angeles Times, and the Minneapolis Star and Tribune. In addition, many newspapers are indexed locally; ask a public librarian about indexes to your local newspaper.

NEXIS

NEXIS is an online search and retrieval service with numerous subfiles of information. The NEXIS database includes the full text of many newspapers, including Legal Times, National Law Journal, the New York Times, the Washington Post, and the Christian Science Monitor; full text of major wire services, including AP, UPI, and Reuters; full text of many newsletters and magazines; full text of some government publications; abstracts to many current affairs magazines and major U.S. newspapers; and other information. Ask a reference librarian if NEXIS is available in your area. There may be a fee for NEXIS searches.

VUTEXT

VUTEXT is a full text online system of regional newspapers that is word-, number-, and phrase-searchable provided by Knight-Ridder, Inc. It provides access to more than 35 regional newspapers in a full text format and in depth coverage of regional business issues. Ask a reference librarian if VUTEXT is available in your area. There may be a fee for searches.

NEWSSEARCH

Newssearch is the daily, commercially-available update of Magazine Index, National Newspaper Index, and Legal Resource Index. It provides front-page to back-page indexing of the Christian Science Monitor, Wall Street Journal, and New York Times, as well as popular magazines, law journals, and legal newspapers. There may be a fee for searches.

VI. GOVERNMENT PUBLICATIONS

FEDERAL DEPOSITORY LIBRARY PROGRAM

Under this program, Government publications are made available to designated depository libraries. In order to provide the general public with greater access to Government publications, these libraries are located in each State and congressional district. There are currently over 1,350 depository libraries. Of this number 50 have been designated as regional depositories. The regional libraries assume the responsibility of retaining depository material permanently and of providing inter-library loan and reference service in their regions. Copies of documents no longer available for sale can usually be found in regional Federal depository library collections. Each issue of the Monthly Catalog of United States Government Publications (see below) prints a current directory of these regional libraries. A directory of all depository libraries is available from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

GOVERNMENT REPORTS ANNOUNCEMENTS AND INDEX

Government research reports are indexed in the Government Reports Announcements and Index, which is issued twice monthly by the National Technical Information Service (NTIS). A keyword index lists significant words from titles. The NTIS index is available online commercially.

MONTHLY CATALOG OF UNITED STATES GOVERNMENT PUBLICATIONS

The Monthly Catalog lists documents issued by all branches of the Federal Government. The catalog has monthly, semiannual, and annual indexes arranged by author, title, subject, keywords, and series/report title. The Monthly Catalog is often the access point for materials in Government depository libraries; it may also be used to obtain information for ordering materials for purchase from the Superintendent of Documents at the U.S. Government Printing Office. The Monthly Catalog is commercially available. Library of Congress subject headings are the catalog's subject authority. Therefore, see search terms under BOOKS in this guide.

The catalog is arranged by agency, and each entry includes the Superintendent of Documents number. At the front of the catalog is a list of beginning (SuDocs) numbers of the agencies. This will be helpful in browsing or in locating materials in those libraries arranging their Federal documents by SuDocs number. (For example, the Health Care Financing Administration, involved in all three aspects of aging policies covered here has the number HE 22.21:982)

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS

The Weekly Compilation of Presidential Documents contains statements, messages, and other Presidential materials released by the White House during the preceding week. The Weekly Compilation has weekly, quarterly, and annual indexes. It is also available online commercially. Rather than searching under the general term of "Aged", items are usually indexed very specifically, e.g. the Pension Benefit Guaranty Corporation, or Home Health Care Week.

INDEX TO U.S. GOVERNMENT PERIODICALS

The Index covers periodical articles published by over 100 Federal agencies, using a thesaurus created exclusively for itself.

Aged (including subdivisions such as Federal aid, Finances, Medical services, Social services)
Health insurance
Home care services
Medicaid
Medicare
Nursing homes
Old-Age, Survivors, and Disability insurance
Retirement
Social Security Act
Social Security Administration

FEDERAL REGISTER

Federal Government regulatory agencies, including Executive Departments publish daily notices and proposed and final rules and regulations. To track a particular regulation being proposed or revised, search under the particular agency's name, such as the Health Care Financing Administration, Human Development Services Office--Administration on Aging, the National Institutes of Health--National Institute on Aging, Pension Benefit Guaranty Corporation, Public Health Service, Social Security Administration, and Veterans Administration.

CENSUS PUBLICATIONS

Begin with the Census Catalog and Guide, 1987, or the most recent volume issued by the Bureau of the Census, available from the G.P.O. It explains what kind of census materials are available in which published format, including printed reports, microfiche, computer tapes, online access, etc. A Factfinder on "Reference sources" lists further sources of assistance on locating and using census materials. CCSP High School Supplement, published by the Census Bureau in 1983 is particularly targeted to high school classroom use by instructors and students.

The Statistical Abstract of the United States is a standard annual summary of statistics on the social, political, and economic conditions in the country. Sections on Population; Vital Statistics; Health and Nutrition; Social insurance and human services; and Income, expenditures and wealth are particularly useful.

SOCIAL SECURITY BULLETIN

This the official monthly publication of the Social Security Administration and is prepared by its Office of Research and Statistics. Every issue includes tables of Current Operating Statistics following the articles. An Annual Statistical Supplement is included in a subscription.

VII. LEGISLATIVE INFORMATION

Congressional activities related to aging policies and concerns may be monitored by searching the following printed publications:

CONGRESSIONAL RECORD

The Congressional Record provides an edited transcript of the activities on the floor of the House and the Senate. It is published each day Congress is in session. The Extensions of Remarks section may provide reprints of newspaper and journal articles as Members of Congress insertions, in addition to those statements spoken by Members on the floor of the House or Senate and recorded by chamber. Subject and name indexes are published biweekly and cumulated annually. Search under such topics as:

Aged
Health
Older Americans Act
Pensions
Social Security Act (includes both Medicaid and Medicare)

CONGRESSIONAL QUARTERLY WEEKLY REPORT

Congressional Quarterly Weekly Report provides current information on congressional activities, the progress of major bills, and background information on major policy issues. Important recent articles are indexed on the back cover of each issue. Consult this index under the headings "Health and "Human services". A quarterly and annual index are also issued; search under such headings as "Aged persons," "Medicaid," "Medicare," "Retirement and pensions," "Social security programs," and "Supplemental Security Income (SSI)." Cross references are also provided.

Congressional Quarterly also publishes an annual volume which cumulates material from the weeklies. There is an index at the back of each volume.

NATIONAL JOURNAL

National Journal provides information on important executive branch and congressional actions. In addition to the weekly and semi-annual indexes, there is a page entitled "Recent Articles" toward the end of most issues. Look under headings for "Demographics," "Health," and "Income security," and sometimes "Politics" (For example, for Jan. 9, 1988 article on the political "clout" of the elderly.).

VIII. BILLS AND RESOLUTIONS

MAJOR LEGISLATION OF THE CONGRESS

This Congressional Research Service publication summarizes major legislation arranged by subject. It includes background on the issues and information on the content and status of major bills affecting that issue. The MLC may be examined at a Government depository library or purchased from the Government Printing Office. Search under the headings "Health", "Income maintenance", and "Social services".

DIGEST OF PUBLIC GENERAL BILLS AND RESOLUTIONS

The Digest summarizes features of public bills and resolutions and changes made in them during the legislative process. The Digest is published by the Congressional Research Service during each session of Congress in two cumulative issues and a final issue at the end of the session. It compiles legislative histories on public laws. The Digest has sponsor/cosponsor, identical bills, short title, and subject indexes. Search the subject index under "Aged" and "Social Security program." Cross references are provided.

CIS INDEX

The CIS Index, produced by the Congressional Information Service, abstracts all congressional publications except the Congressional Record. The Index is published monthly and cumulated quarterly and annually. Each issue of the Index is divided into index and abstract portions. CIS also publishes legislative histories annually. Search in the index section under such headings as:

Aged and aging
Geriatrics and gerontology
Home health services
Hospitals and nursing homes
Housing for the aged
Medicaid
Medicare
Pensions
Respite care
Retirement
Retirement income
Social security
Supplemental security income program

Also use the cross-references provided. Refer to the abstract section for full bibliographic information.

CONGRESSIONAL INDEX

The Congressional Index, published by the Commerce Clearing House, is a weekly looseleaf service providing content and status information for bills and resolutions pending in Congress. The progress of bills and resolutions is reported from the introduction of the legislation to the final disposition.

IX. STATISTICAL SOURCES

For census and Social Security statistics, see also the Federal Government sources section above.

AMERICAN STATISTICS INDEX (AIS)

The American Statistics Index indexes and describes the statistical publications of the U.S. Government, including periodicals, annuals, biennials, semi-annuals, and special publications. The Index provides access to statistical materials by subject, organization, name, issuing source, and title. The Index is published monthly and cumulated quarterly and annually. ASI is available online commercially. Search under "Aged" and "Aged and Aging."

STATISTICAL REFERENCE INDEX

The Statistical Reference Index provides a guide to selected statistical reference material from non-Federal sources on a wide spectrum of subject matter. It includes the publications of trade, professional, and other non-profit assocations and institutions, business organizations, commercial publishers, university and independent research centers, and State government agencies. The Index provides access by subject, organization, name, issuing source, and title. The Index is published monthly and cumulated annually.

AGING AMERICA: TRENDS AND PROJECTIONS

Prepared by the U.S. Senate Special Committee on Aging in conjunction with the American Association of Retired Persons, the Federal Council on the Aging, and the U.S. Adminstration on Aging. 3rd ed. Washington, U.S. Dept. of Health and Human Services, 1987. 186 p.

STATISTICAL POLICY FOR AN AGING AMERICA

A Joint Hearing by a Senate Committee on Governmental Affairs Subcommittee and the Senate Committee on Labor and Human Resources, Subcommittee on Aging, 1986, (Joint hearing, Senate, 99th Congress, 2nd session, S. hrg. 99-858) includes the National Research Council Panel on Statistics for an Aging Population's "Inventory of data sets related to the health of the elderly," p. 241-657.

HEALTH STATISTICS ON OLDER PERSONS, UNITED STATES, 1986

By Richard Havlik, and others, published by the U.S. National Center for Health Statistics, for sale by the Supt. of Docs, G.P.O., 1987. 157 p. (Vital and Health Statistics, Series 3, Analytical & Epidemilological Studies, no. 25; DHHS publication no. (PHS) 87-1409).

DATABOOK ON THE ELDERLY, 1987

By Michele Adler, Suzanne Kitchen, and Albert Irion. Submitted by Macro Systems to the U.S. Dept. of Health and Human Services, 1987. 259 p. Also appears on LOTUS diskettes for use through a personal computer.

STATISTICAL HANDBOOK ON AGING AMERICANS

This handbook, edited by Frank L. Schick, was published in Phoenix, AZ by Oryx Press, 1986. 294 p.

AMERICA'S CENTENARIANS: DATA FROM THE 1980 CENSUS

These statistics were compiled by Gregory Spencer and published by the National Institutes of Health in 1987.

CATALOG OF DATA COLLECTIONS OF THE NATIONAL ARCHIVE OF COMPUTERIZED DATA ON AGING

This catalog is published by the Inter-university Consortium for Political and Social Research, Ann Arbor, Mich.

NATIONAL DATA BASE ON AGING

This is a data base dealing with statistics about the elderly and the services provided by the network of State and Area Agencies on Aging. For more information, contact the National Association of State Units on Aging, 2033 K Street, N.W., Suite 304, Washington, D.C., 20006.

X. FURTHER CONTACTS

FEDERAL GOVERNMENT AGENCIES

The following is a list of some of the Federal agencies which may be able to provide materials on the debate topic. Some of the guides to organizations will provide information about agencies listed here and other agencies. The annual report of the Senate's Special Committee on Aging, Developments in Aging: 1986, and other years, "summarizes and analyses the Federal policies and programs that are of the most continuing importance for older persons, their families, and for those who hope to become older Americans in the future." The 2nd volume in 1986 discussed these by agency.

Public assistance programs programs are fully described in Background material and data on programs within the jurisdiction of the Committee on Ways and Means, 1987 edition. Issued as committee print WMCP: 100-4, House Committee on Ways and Means, 100th Congress, 1st session.

Federal Council on the Aging
Dept. of Health and Human Services
North Building, Rm. 4243
330 Independence Ave., S.W.
Washington, D.C. 20201
(202) 245-2451

Administration on Aging
Dept. of Health and Human Services
Office of Human Development Services
200 Independence Ave., S.W.
Washington, D.C. 20201
(202) 245-0556

National Institute on Aging,
National Institutes of Health
Bethesda, MD 20892
(301) 496-5345

Health Care Financing Administration
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 245-6726

Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235
(301) 594-1234

STATE AND AREA AGENCIES ON AGING

The National Association of State Units on Aging and the National Association of Area Agencies on Aging, also relate to the U.S. Administration on Aging in an intergovernmental and public non-profit network.

State and area agencies on the aging, and their advisory councils are very aware of State and local resources and services on the aging, and can offer debaters a chance to gain regional or local perspectives on these national public policy issues.

A Directory of State and area agencies on aging. Compiled by the Select Committee on Aging, House of Representatives, 99th Congress, 1st session. 4th ed. Washington, For sale by the Supt. of Docs., G.P.O., 1985. 143 p.
At head of title: Committee print.
"Comm. pub. no. 99-490."

GUIDES TO ORGANIZATIONS

There are many public policy-oriented organizations. Some organizations may be able to provide information by correspondence or a list of publications available for sale. The list of books which follows is a selection of some of the many available guides to organizations.

Encyclopedia of associations. Detroit, MI, Gale Research Company. 4 v.
"The Encyclopedia of Associations consists of the following volumes: Volume 1, National Organizations of the United States, detailed descriptions of national trade, professional, and other organizations; Volume 2, Geographic and Executive Indexes, covering material in Volume 1; Volume 3, New Associations and Projects, periodic reports listing additional associations not included in Volume 1. Volume 4, International Organizations, detailed descriptions of international trade, professional, and other organizations; and, International Organizations Supplement, periodic reports listing additional associations not listed in Volume 4.

Encyclopedia of Governmental Advisory Organizations. Detroit, MI, Gale Research Co.
Use the name and keyword index in Volume 1, Part 3.
"A reference guide to approximately 5,000 permanent, continuing, and ad hoc U.S. presidential advisory committees, congressional advisory committees, and other agencies.

Research Centers Directory. Edited by Robert C. Thomas and James A. Rullner. Detroit, MI, Gale Research Co.
A guide to university-related and other nonprofit research organizations established on a permanent basis and carrying on continuing research programs in agriculture, business, conservation, education, engineering and technology, government, law, life sciences, mathematics, area studies, physical and earth sciences, social sciences, and humanities.

United States Government manual. Prepared by the U.S. Office of the Federal Register. Washington, G.P.O.
Use the subject/agency index to identify Federal agencies with responsibilities in the area of aging.

Washington information directory. Washington, Congressional Quarterly.
This directory, which is updated yearly, lists both governmental and nongovernmental organizations with headquarters or branch offices in Washington, D.C.

Examples of the kinds of organizations to search for in these directories are listed here. Look for both general public policy research organizations, such as:

American Enterprise Institute for Public Policy Research
Brookings Institution
Cato Institute
Heritage Foundation
National Bureau of Economic Research
Urban Institute;

for specialized organizations, such as:

American Association of Retired Persons
American Federation of Home Health Agencies
American Society for Aging
Center for the Study of Aging
Employee Benefits Research Institute
Gerontological Society of America
National Center for Home Equity Conversion
National Citizens' Coalition for Nursing Home Reform

and for those aligned with an institution of higher education, such as:

Brandeis University. Florence Heller Graduate School for Advanced Studies in Social Welfare
George Washington University. National Health Policy Forum
Johns Hopkins University. School of Hygiene and Public Health
University of California, San Francisco. Institute for Health & Aging
University of Southern California. Ethel Andrus Gerontology Center
University of Wisconsin-Madison. Institute for Research on Poverty

When looking for national organizations dealing with the aged, retirement income, and aging, note that new organizations are constantly being formed, such as Generations United, "a national coalition of intergenerational issues and programs," which was formed in 1986 and publishes a newsletter under the auspices of the Child Welfare League of America, 440 First St., N.W., Suite 310, Washington, D.C. 20001.

PERSONAL CONTACTS

Some of the potentially most valuable contacts the debater may want to pursue are personal ones. Talking with the elderly themselves, either in their homes or in residential or day care facilities, could be a source of insight which could enrich the published literature. The interrelationships of issues become more evident as one encounters real-life situations and human emotions. Public policy successes and failures can be debated from statistical evidence and published evaluations, but the high school debater will find personal observations could help these "facts" to merge together as he or she compiles arguments and positions. Preparation for these visits would be advisable, particularly to make arrangements through appropriate staff. Before a visit, one might wish to read one of these books written specifically for young people about aging.

Guthrie, Donna.
Grandpa doesn't know it's me. Human Sciences Press, c1986. 32 p.
An example of juvenile literature about Alzheimer's disease.

Landau, Elaine.
Growing old in America. New York, J. Messner, c1985. 143 p.
Discusses aspects of growing old in America, such as retirement, senior citizens centers and communities, financial matters, and health problems.

McConnell, Nancy P.
Young & old alike. Colorado Springs, Current, c1984. 24 p.
Explains the aging process, advantages and problems of being old, and the many things the old and young have in common.

Phenice, Lillian A.
Children's perceptions of elderly persons. Saratoga, Calif., Century Twenty One Pub., c1981. 105 p.
Discusses common stereotypes held by children about the aged.

Worth, Richard.
You'll be old someday, too. New York, F. Watts, 1986. 118 p.
Explores current attitudes toward aging and the elderly in the United States. Also includes interviews with retirees from various parts of the country discussing how they are managing their lives.

UNITED STATES GOVERNMENT PRINTING OFFICE
SUPERINTENDENT OF DOCUMENTS
WASHINGTON, D.C. 20402

SB-043
March 16, 1988

PUBLICATIONS RELATING TO THE 1988-89 HIGH SCHOOL DEBATE TOPIC

Aging: What should the Federal Government do to enhance the quality of life for United States citizens over age 65?

* * * * * * * * * * * * * *

___Aging. (Quarterly.) *A medium for sharing information about programs and activities among interested individuals, agencies, and organizations in the field of geriatrics.* Subscription price: Domestic - $5.00 a year; Foreign - $6.25 a year. Single copy price: Domestic - $2.00 a copy; Foreign - $2.50 a copy. (AGING) (File Code 2G)
HE 23.3110: S/N 717-003-00000-4

___America in Transition: An Aging Society. *Presents a compendium of facts brought together to provide a readily usable profile of the demographic, social, and economic circumstances of older members of American society.* 1983: 31 p.; ill.
C 3.186:P-23/128 S/N 003-001-91543-0 $ 3.50

___Background Materials on Health Care Coverage and Expenses of the Medicare Population. 1987: 73 p.; ill.
Y 4.W 36:WMCP 100-10 S/N 052-070-06306-8 2.25

Compilation of the Social Security Laws, Including the Social Security Act, as Amended, and Related Enactments Through January 1, 1987:

___ Volume 1. 1987: 1086 p.
Y 4.W 36:10-3/986/v.1 S/N 052-070-06327-1 26.00

___ Volume 2. 1987: 968 p.
Y 4.W 36:10-3/986/v.2 S/N 052-070-06328-9 26.00

___Developments in Aging: 1985, Volume 1, A Report of the Special Committee on Aging, United States Senate, Pursuant to S. Res. 85, Section 19, February 28, 1985, Resolution Authorizing a Study of the Problems of the Aged and the Aging. *Topics covered include: retirement income; low income assistance programs; health; housing; and social services.* 1986: 444 p.
Y 1.1/5:99-242/v.1 S/N 052-071-00706-7 12.00

___Exploding the Myths: Caregiving in America, A Study. *Underscores the continuing contribution of the family in providing care to the frail and disabled elderly.* 1987: 81 p.; ill.
Y 4.Ag 4/2:M 99/2 S/N 052-070-06342-4 2.50

___Graying of Nations 1, Hearing Before the Special Committee on Aging, Senate, 99th Congress, 1st Session, July 12, 1985. *Presents the testimony of congressional leaders, members of the medical community, social workers, and State and local officials regarding various aspects of aging in the United States and throughout the world.* 1986: 170 p.; ill.
Y 4.Ag 4:S.hrg.99-573 S/N 052-070-06113-8 $ 4.75

___Health Care Financing Extramural Report: Evaluation of Community-Oriented Long-Term Care Demonstration Projects. *Summarizes major findings from the national evaluation of 13 projects that provided and financed publicly supported community-based long-term care to impaired and aged Medicare and Medicaid beneficiaries.* 1987: 408 p.; ill.
HE 22.19/9:C 73/2 S/N 017-060-00199-2 18.00

___Initial Findings From the Medicaid Tape-to-Tape Project. 1987: 41 p.; ill.
HE 22.19/4-2:M 46/15 S/N 017-060-00193-3 2.25

___Long-Term Care: Background and Future Directions. 1981: 80 p.
HE 22.2:C 18 S/N 017-062-00126-0 4.75

___Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, Conference Proceedings, January 24, 1984, Washington, D.C. 1984: 141 p.
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___Medical Technology and Costs of the Medicare Program. 1984: 242 p.; ill.
Y 3.T 22/2:2 M 46/6 S/N 052-003-00957-9 7.50

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___Nursing Home Care: The Unfinished Agenda, An Information Paper, May 1986. *Contains findings of a two-year investigation on the quality of care provided in the nation's nursing homes. The conclusions were based on interviews with patients, nursing home personnel, government officials, and an analysis of Federal inspection reports over a five year period.* 1986: 48 p. Y 4.Ag 4:S.prt.99-160 S/N 052-070-06155-3 1.50

___Older Americans Act Amendments of 1986, Public Law 99-269. An Act to Amend the Older Americans Act of 1965 to Increase the Amounts Authorized to be Appropriated for Fiscal Years 1985, 1986, and 1987 for Commodity Distribution, and for Other Purposes. Approved April 1, 1986. 1986: 3 p.
AE 2.110:99-269 S/N 822-009-00029-8 1.00

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HE 3.2:R 31/14/v.2 S/N 017-070-00430-0 14.00

___United States National Report on Aging for the United Nations World Assembly on Aging. *Overview of social and economic issues involving the growing population of senior citizens in the United States and other developed countries, as presented to the United Nations World Assembly of Aging.* 1982: 138 p.; ill.
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